Medical Economics

JANUARY

POINTERS FOR PROSPECTIVE SPECIALISTS . . . See page 55

PHYSICIAN

and surroun

WHEN in Chicago's Loop a hearty welc awaits you at our new enlarged quarters, w you find the widest selection of PHAR CEUTICAL PREPARATIONS, including standard products from leading American foreign laboratories.

FOR ECONOMY AN

NORTHSIDE BRANCH
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Why rely on one... when all 3 are combined in the

New BIODYNE Burn Therapy

1 **PETROLATUM,** the base of Bio-Dyne Ointment, is itself a widely accepted local aid. It maintains soft coagulum and minimizes crusting under which infections might develop.

2 **COMPRESSION BANDAGES** limit edema within the lesion and deeper sub-structures, thus markedly decreasing fluid loss from the burned surface in addition to keeping ointment in contact with lesion.

3 **BIO-DYNE OINTMENT** increases the effectiveness of the compression bandage and petrolatum (its base) therapy by the addition of biodynes. Biodynes are natural cellular products which help regulate cellular proliferation and metabolism and tend to offset the depressing effects of germicides on tissue respiration.

BIO-DYNE
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Medical Economics

THE BUSINESS MAGAZINE OF THE MEDICAL PROFESSION

JANUARY 1946

Cover photograph by Ewing Galloway

CIRCULATION 114,000

H. Sheridan Baketel, A.M., M.D., Editor-in-Chief. William Alan Richardson, Editor. Ross C. McCluskey, Managing Editor. Lansing Chapman, Publisher. W. L. Chapman, Jr., Business Manager. R. M. Smith, Sales Manager.

25c a copy; $2 a year (Canada, $2.50 a year).

THE CASE OF THE RABBITS

that saved a settlement... for a doctor, a hospital... perhaps you!

Frankly, these rabbits were very unhappy! Comfortably ensconced in cages at Cutter Laboratories, they were nonetheless uniformly suffering from what is commonly known as "a reaction." You know—chills, fever, general malaise.

The morning in question, Cutter workers who busy themselves being "purists," gave these rabbits each an injection. The material was one of our famous Saftiflask Solutions, made by experts using equipment with every modern, fool-proof safety device. But despite all this careful control exercised in production—the meticulous care that is routine in a biological laboratory—an impurity had invaded the material.

The unhappy rabbits were Cutter's warning—and *your protection*. Lot #5456 was promptly DUMPED. It only goes to show that no human is error-proof—no equipment is perfect. This is not the first lot, nor will it be the last, to be dumped down Cutter drains.

MORAL: When we reach the Utopia, peopled with error-proof humans working with perfect equipment, simply prescribe "Dextrose I. V." Until then, for peace of mind, add the word "Cutter."

Let Cutter's Smith tubes and culture plates chance infection with bacterial or mold contamination. Let Cutter rabbits, *not your patients*, suffer the pyrogen reactions!

CUTTER LABORATORIES, BERKELEY
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CUTTER *Saftiflask Solutions*

These Three B-D Steritubes

protect your sterilized instruments

SAVE MONEY and TIME

No. 17
FEVER THERMOMETER STERITUBE

Durable glass case carries thermometer in sterilizing solution, cushioned from shock by stainless steel ejector spring. Metal cap fits snugly on ground luer tip to prevent leakage.

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Boilable metal holder carries sterile syringe and needle ready for instant use—in home or office. Rubber cap and washer cushion syringe from shock and withstand sterilization. Suspension of needle point prevents damage.

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Keeps sterile needles ready for use. Glass permits sterile inspection of protected points, gauge and size. Flared glass rims and gripping rubber caps insure continued sterility. All parts boilable.

B-D PRODUCTS
Made for the Profession

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What's the

CLOTTING TIME?

IN THE CONTROL of capillary or venous bleeding, the reduction of clotting time is invariably an important contributing factor. KOAGAMIN,* injected either intramuscularly or intravenously, has been shown materially to reduce the clotting time of the blood.

In hemorrhagic diseases, abnormal bleedings, blood disorders and in surgery, *prior prophylactically* KOAGAMIN should be a first consideration at all times — a wise precaution — a definite adjunct to the control of bleeding.

Abundant clinical reports of its successful use testify not only to its value as a dependable hemostatic agent but add impressive evidence as to its non-toxicity.

Chatham

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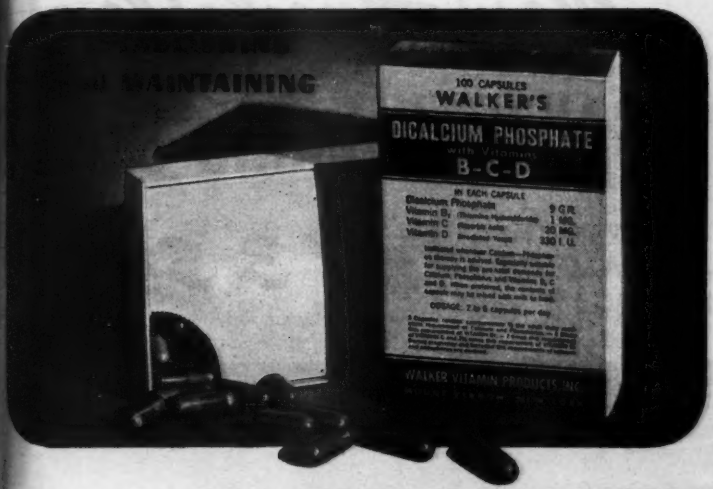

THE CALCIUM-PHOSPHORUS BALANCE

The need for maintaining a favorable calcium-phosphorus balance throughout pregnancy and lactation is generally recognized. Important links in promoting satisfactory mineral metabolism and the health of cellular and intercellular tissue elements are supplied by vitamins B_1, C and D. Pre- and postnatally the need for these vitamins is greatly increased.

WALKER'S DICALCIUM PHOSPHATE with VITAMINS B_1-C-D

fully meets the need for a product which will supply these dietary supplements in a form readily acceptable to the patient. Supplied as capsules or tablets.

Available through all prescription pharmacies. You assure quality when you specify a Walker product.

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VITAMIN PRODUCTS, INC., MOUNT VERNON, N. Y.

Now Available

NU GAUZE* PACKING STRIPS

PLAIN (UNMEDICATED)
SULFATHIAZOLE (10%)
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Plain (unmedicated)—¼", ½", 1" and 2" x 5 yds.

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ORDER FROM YOUR DEALER

Johnson & Johnson
NEW BRUNSWICK, N. J. CHICAGO, ILL.

*Trade-mark of Johnson & Johnson

Panorama

► Battery of labor lobbyists descended on Washington just forty-eight hours after new Wagner-Murray-Dingell bill (S.1606) had been introduced . . . Break-up of Germany's I. G. Farbenindustrie, which supplied 60 per cent of world's pharmaceuticals before the war, is expected to boost American drug exports to $100 million in 1946, four times the prewar figure . . . Naval Hospital at Arrowhead Springs reports that vets are considered "recovered" when they start calling the nurses for appointments, instead of the doctors, says Danton Walker . . . Persons earning below $5,000 a year account for 45 per cent ($59 billion) of savings accumulated since Pearl Harbor, medical collection agencies will be glad to learn . . . Doctors planning to relocate in Alaska are chilled by gloomy picture painted by Governor Ernest Gruening. The territory won't develop more than 15,000 new jobs in the next ten years, he predicts.

► As newspapers conjured up visions of ice cream, frankfurters, and hamburgers "fortified" with penicillin, California's horrified state board of pharmacy couldn't decide whether the drug should be sold over the counter or only on doctor's prescription . . . When 600 apartments in the Bronx were vacated, owners agreed to give priority in rental to (1) disabled veterans, (2) doctors connected with the local V.A. hospital, and (3) veterans with two years' service overseas . . . More and more county medical societies report buying advertising space to urge former patients to return to physicians recently released from armed services. Not only the ex-medical officer's name, but also his address and phone number are being included.

► Thirteen thousand Army medical officers received New Year greetings, in the form of discharges from service, six weeks before the Dec. 31 deadline originally set . . . Too many people fatally injured by falling out of bed, says Metropolitan Life, calling bedroom worst hazard in the house . . . Thirteen medical consultants from staffs of Northwestern and Illinois universities appointed by V.A. to Hines (Illinois) Hospital at $6,000 a year . . .With 1945 births up 35 per cent over 1944's, Soviet authorities are rubbing hands over their bonus system. New baby brings 400 rubles to mother of three children; scale ranges up to 5,000 rubles for

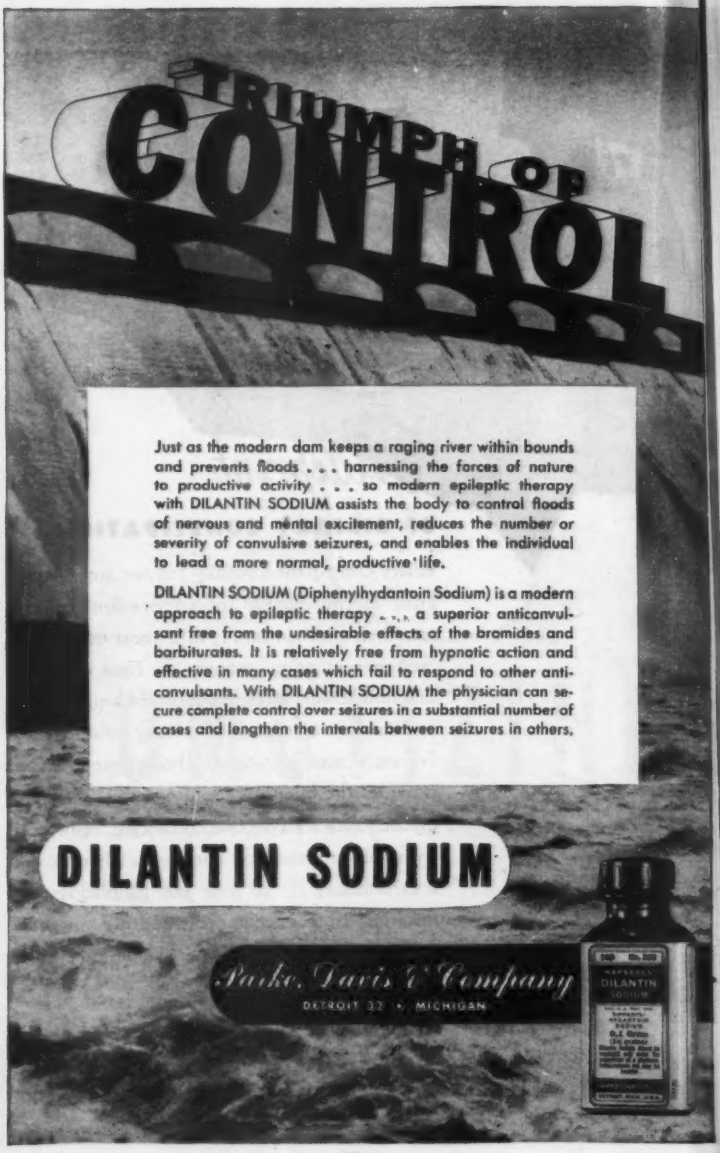
...blueprint OF BILIARY CONSTIPATION...

Biliary constipation usually follows any disturbance of the closely interdependent biliary-intestinal mechanism... in a most stubbornly "self-perpetuating" manner. • Thus decreased bile flow lowers intestinal motility; and (in turn) intestinal stasis aggravates biliary insufficiency. For such cases, 'Veracolate' cholagogue-evacuant provides the bile salts sodium taurocholate and glycocholate for effective choleresis...reinforced by small amounts of effective cathartics and a carminative... to help put gallbladder and intestinal tract once more smoothly "in gear."

MARCY LABORATORIES, INC., NEW YORK 11, N. Y.

VERACOLATE

CHOLAGOGUE-EVACUANT


TRIUMPH OF CONTROL
Just as the modern dam keeps a raging river within bounds and prevents floods . . . harnessing the forces of nature to productive activity . . . so modern epileptic therapy with DILANTIN SODIUM assists the body to control floods of nervous and mental excitement, reduces the number or severity of convulsive seizures, and enables the individual to lead a more normal, productive life.
DILANTIN SODIUM (Diphenylhydantoin Sodium) is a modern approach to epileptic therapy . . . a superior anticonvulsant free from the undesirable effects of the bromides and barbiturates. It is relatively free from hypnotic action and effective in many cases which fail to respond to other anticonvulsants. With DILANTIN SODIUM the physician can secure complete control over seizures in a substantial number of cases and lengthen the intervals between seizures in others.
DILANTIN SODIUM
Parke, Davis & Company
DETROIT 32 • MICHIGAN
DILANTIN
SODIUM

mother with more than ten . . . When Drs. L. H. Bauer and Ernst P. Boas debated compulsory health insurance in Nyack, N.Y., a policeman, in order to report an emergency, had to come to the hall to do so; every doctor in town was there.

▶ Facing court martial last month was Alphonse J. Fabbricatore, Major, Medical Administrative Corps, charged with having "sold" medical discharges and transfers at Mitchel Field, New York . . . With its drug industry ruined and with limited prospects of imports from other nations, Germany is said to face serious winter epidemics . . . Doctors a month ago held little hope for Abe Cohen, Honolulu victim of lymphatic leukemia who offered his $11,000 life savings for a blood transfusion from someone who had recovered from the disease . . . Medical men are lax about giving "enlightened sex education," and educators are worse, charges Hazel Corbin, director of New York's Maternity Center Association.

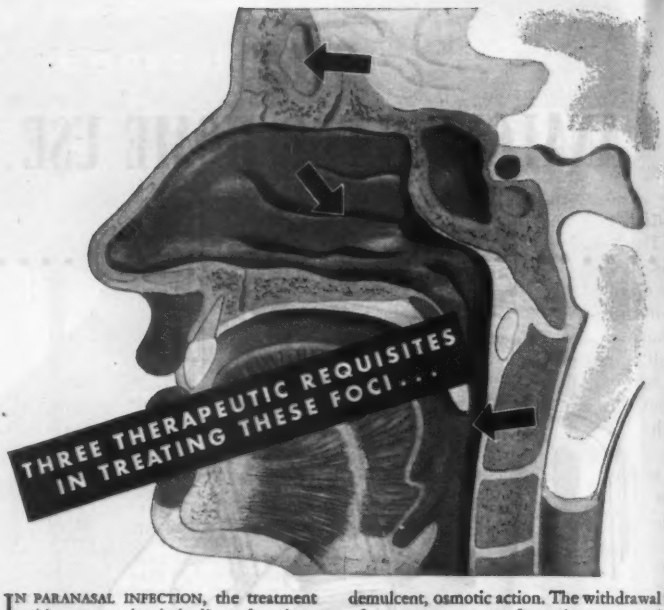
▶ Why confine a "march of dimes" or a President's birthday ball to raising funds to fight a single disease? asks Samuel A. Levine, Boston cardiologist. His proposal: a single national drive to finance research in all diseases . . . There will be no Negro race left in the U.S. 300 years hence, according to Dr. Ralph S. Linton, professor of anthropology at Columbia University. The white race, he declares, is gradually absorbing all Negroes, so that today only 10 per cent of the latter are pure strains . . . Pausing in her attack on Red Cross "fuddy-duddies" who are "against labor," Mrs. Eugene Meyer, wife of the publisher of The Washington Post, last month resumed her plumping for a cabinet seat for "education, health, welfare, and social insurance". . ."Insult to injury" is what the Wall Street Journal calls a proposal to tax ambulance rides in Los Angeles. Adds the Redwood City (Cal.) Tribune: "Accidents have a way of victimizing people without reference to their ability to pay for the ambulance ride, let alone an added tax". . . Release of surplus medical supplies will continue at slow pace "until the Chinese situation is cleared up," say Washington dopesters.

▶ The British Medical Journal regrets that the bill for a British national health service was not brought before Parliament by the late, wartime, coalition government. That government, it feels, would have tried to make the service as acceptable as possible to the profession; whereas the new, socialist, labor government has stated that "only a system of whole-time salaried and pensionable doctring will meet the requirements" . . . Chicago Daily News, in cooperation with county medical society, recently published complete list of physicians back in practice after war service . . . Commenting on enrollment of girls in medical schools, University of Illinois says, "The chief trouble with women in medicine is matrimonial."

The
ANALGESIC FOR HOME USE..

THE Bayer Laboratories at Rensselaer, N. Y., have specialized in the production of Aspirin for over forty-seven years. Only the finest and purest ingredients are used in its manufacture. Every batch made is subjected to complete and rigid scientific controls. Seventy different tests and inspections have been developed to insure the quality, purity and uniformity of the finished product.

BAYER *ASPIRIN*



IN PARANASAL INFECTION, the treatment with ARGYROL is wisely directed to these three foci:

1. the nasal meatus . . . by 20 per cent ARGYROL instillations through the naso-lacrimal duct.
2. the nasal cavities . . . with 10 per cent ARGYROL solution in drops or by nasal tamponage.
3. the fauces and pharynx . . . by swabbing with 20 per cent ARGYROL solution.

Marked relief generally follows because ARGYROL offers more than effective antisepsis, decongestion without vasoconstriction, and cleansing of the membrane. It provides also for stimulation of the membrane's inherent, natural defense mechanism.

HOW ARGYROL ACTS

DECONGESTIVE—ARGYROL's decongestive effect in the membrane is the result of its demulcent, osmotic action. The withdrawal of ARGYROL tampons from the post-nasal cavities frequently brings forth a long ropy mucous discharge measuring as much as two feet or more.

BACTERIOSTATIC—Although proved to be definitely bacteriostatic, ARGYROL is non-toxic to tissue. In nearly a half century of wide medical use of ARGYROL, no case of toxicity, irritation, injury to cilia or pulmonary complication in human beings has ever been reported.

STIMULATING—Soothing to nerve ends in the membrane and stimulating to glands, ARGYROL's action is more than surface action. For it acts *synergistically* with the membrane's own tissue defense mechanism.

When you order or prescribe ARGYROL, make sure you specify Original Package ARGYROL.

ARGYROL

THE PHYSIOLOGIC ANTISEPTIC WITH SYNERGETIC ACTION . . .

***Made only by the* A. C. BARNES COMPANY, NEW BRUNSWICK, N. J.**

ARGYROL is a registered trademark, the property of A. C. Barnes Company

Speaking Frankly

Raus

The hospital staff situation is serious. At Christ Hospital, Jersey City, we do not have enough beds for patients of the present regular staff; what will happen when about sixty staff men return from service?

And that involves the very thing I have been preaching for five years –the Blue Cross. I think it should be abolished, for it is getting so big it is overrunning itself. What right has it to guarantee hospitalization when it doesn't have a cent invested in hospitals? The Blue Cross makes money and pays big salaries, but a large, modern hospital–no matter how well it is organized–cannot make money.

George F. Mangone, M.D.
Union City, N.J.

Lagniappe

The California medical officer who complains that he was charged $100 by a colleague for delivering a baby in a charity case in which he was interested, cannot have been around much. I was charged $50 for a physical examination and fluoroscopy by a professional brother in Memphis, Tenn. In the same city, my baby could get no attention from a pediatrician unless I slipped him an occasional fifty. A doctor in San Antonio, Texas, charged me $5 for a blood culture on my own blood; he reported the count but for eighteen months I've been waiting for the outcome of the culture. I know a Baton Rouge doctor who was charged $150 for an appendectomy by a New Orleans colleague. And finally, there is the Louisiana physician I heard about who was taking post-graduate work in Philadelphia –and charged one of his teachers $150 for a jaw operation.

M.D., Texas

Freezeout

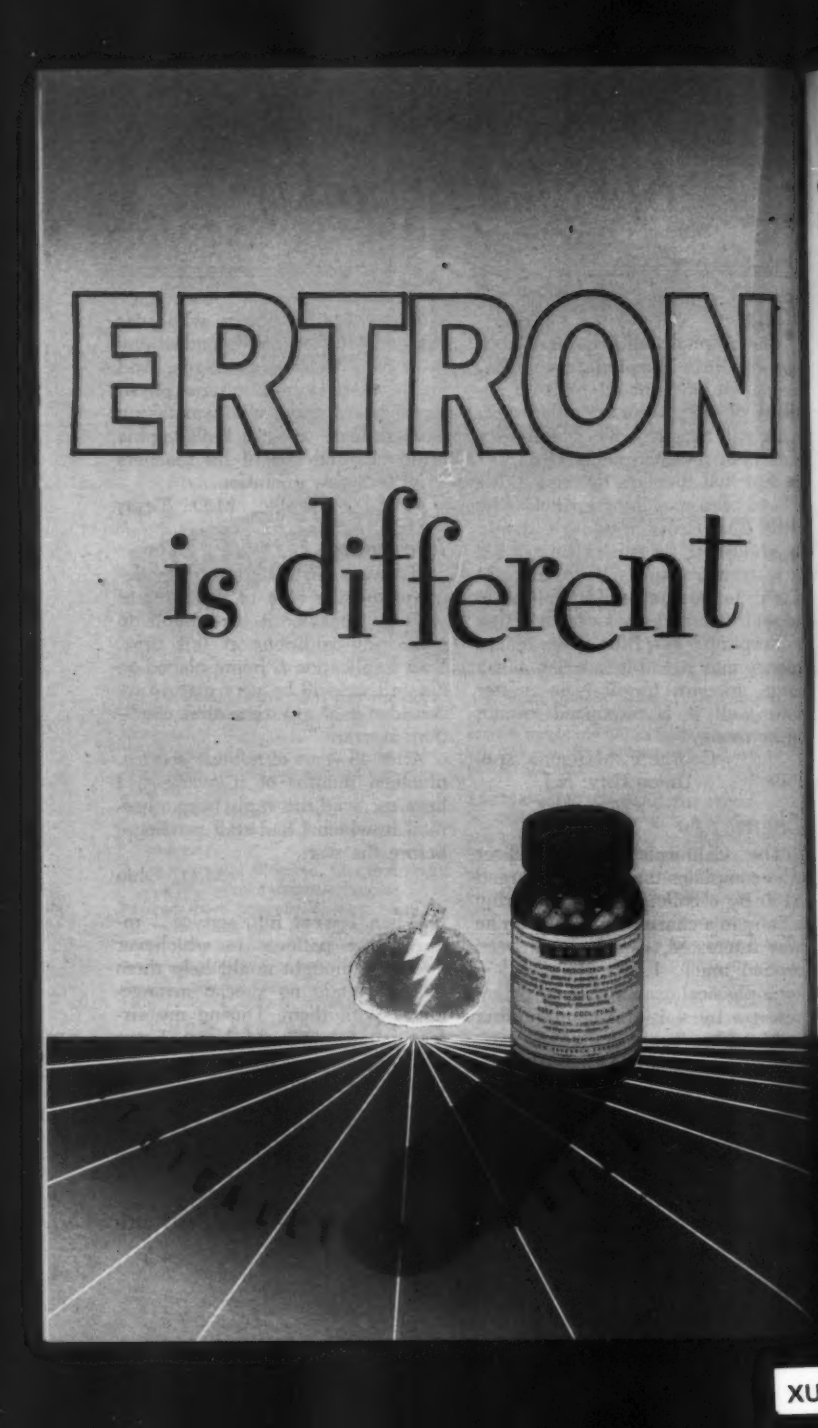
"Because our facilities are inadequate to take care of our present staff we consider it inadvisable to make any additions at this time. Your application is being placed on file and we will be very glad to reconsider it at any time that conditions warrant."

After 4½ years of military service, nineteen months of it overseas, I have received this reply from a hospital in which I had staff privileges before the war.

M.D., Ohio

When I went into service I referred my patients to whichever doctors I thought might help them most. I made no special arrangements with them. During my sixteen months with the Navy, I was stationed at a place only a hundred miles from my home town, so I was able to make an occasional trip back. Whenever I did I visited the hospitals and talked with the doctors, in order to learn how my patients were getting on.

Even then the home-front atti-


ERTRON
is different

• *Therapeutically and chemically,* Ertron differs from any other drug used today in the treatment of chronic arthritis.

• *10 years* of intensive clinical research has established the efficacy of Ertron in the management of arthritis.

• *5 years* of laboratory research has produced definite evidence that Ertron is chemically different.

Simply stated, Ertron is electrically activated vaporized ergosterol prepared by the Whittier Process.

Ertron contains a number of hitherto unrecognized factors which are members of the steroid group. The isolation and identification of these substances in pure chemical form further establishes the chemical as well as the therapeutic uniqueness of Ertron.

Each capsule of Ertron contains 5 mg. of activation-products having a potency of not less than 50,000 U.S.P. Units of vitamin D.

To Ertronize the arthritic patient, employ Ertron in adequate daily dosage over a sufficiently long period to produce beneficial results.

The usual procedure is to start with 2 or 3 capsules daily, increasing the dosage by 1 capsule a day every 3 days until 6 capsules a day are given. Maintain medication until maximum improvement occurs. A glass of milk, 3 times daily following medication, is advised.

Supplied in bottles of 50, 100 and 500 capsules.
Parenteral for supplementary intramuscular injection.

Ertron is the registered trade-mark of Nutrition Research Laboratories

tude was pretty plain: "You're out, young fellow, and we hope you stay away." When I was discharged the chill became even more intense. For instance, I asked the local paper to print a brief item about my return but found the editor completely indifferent. Finally, I had to go down to the office, type up the item, and read proof on it myself.

I learned that some of my patients during my absence had purposely made themselves transients so they would be able to return to me later. But about 25 per cent had not done so—and I've never seen them since. There is no doubt in my mind that my colleagues have prejudiced such patients against me. In any event, they haven't made the slightest attempt to return them. The hospital has lived up technically to its agreement to reinstate me. But whereas I worked as assistant to a certain physician before the war, there is never any mention of my handling a case with him now.

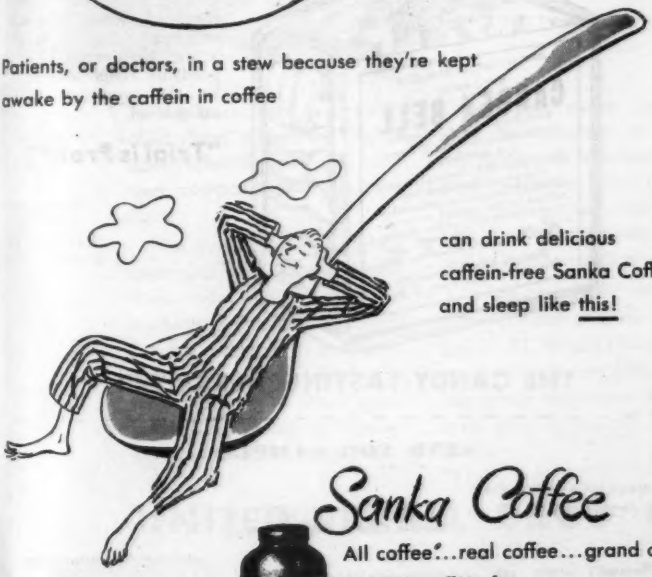
Four other men from my town are still in service, and I've been in touch with them. When they get back we're going to get together and start some fireworks. We shall demand a program of reinstatement of medical veterans in fact—and not merely in theory.

M.D., Maine

Mess

I wish something could be done about this compensation mess. The red tape is unbearable. To collect a $4 bill I have to fill out and mail three different forms. Weeks later I am usually notified that the forms "have not been received" or "have been mislaid" or that it will be necessary for me to "send in final forms"

Patients, or doctors, in a stew because they're kept awake by the caffein in coffee



can drink delicious caffein-free Sanka Coffee and sleep like this!

Sanka Coffee

All coffee's...real coffee...grand coffee ...97% caffein-free

A Product of General Foods

FIGHT INFANTILE PARALYSIS

To the parents of a stricken child there is nothing "light" about infantile paralysis, however comparatively mild the case.

Nor is this scourge lightly regarded by millions of Americans who are learning to evaluate its threat. Much credit for this advance in public interest and support is due to the unflagging efforts of members of the National Foundation for Infantile Paralysis.

Now, as every January since its inception in 1938, this group is conducting a great drive for funds to continue combating poliomyelitis with the finest research and skill known to medical science.

In co-operation with the current March of Dimes, January 14-31, Rexall Drug Stores across the country join in urging every American to work and give in behalf of this cause.

UNITED-REXALL DRUG CO.

Rexall
DRUGS

Pharmaceutical chemists for more than 42 years
Los Angeles • Boston • St. Louis • Chicago • Atlanta • San Francisco
Portland • Pittsburgh • Ft. Worth • Nottingham • Toronto • So. Africa

(which are exactly the same as the first ones!). Life is thus a continual sparring match with the insurance companies.

A year and a half ago I advised a hernia operation ($75) for a compensation patient; not until a month ago was I permitted to do it. Meantime, there had been all manner of disagreements with the carrier, including a suggestion on its part that the patient get along with a truss.

My solution would be the creation of a board composed, not of insurance men, but of physicians and other professional people qualified to understand doctor-patient relationships. Such a board could be expected to give quick, impartial decisions.

M.D., New York

Why can't insurance companies authorize the employer to pay the physician directly for obvious compensation cases that require only two or three visits, then reimburse the employer when he presents his receipt?

Warren A. Harrison, M.D.
Fort Myers, Fla.

Whizbang

That communicant signing himself "M.D., Washington," who boasts that he is pulling down $30,000 a year as a G.P. although he has been practicing only seven years, must be a wizard—a whizbang of the first magnitude. Understand, he's not a specialist, just a plain general practitioner. But evidently he is geared to the machine age, motored like a B-29, and endowed with the genius of a Morgenthau.

I figure that to earn such an in-

REED & CARNRICK

PARENTERAL MEDICAMENTS

• This remarkable offer applies to *every* Reed & Carnrick parenteral, *every* package size, *every* unitage. Place an order with your dealer, or direct, for 3 multidose vials, or 3 boxes of ampuls of the same size and unitage, and you will receive another at no extra cost. For example, purchase 3—20 cc. vials Estrogenic Hormones, R & C, 25,000 I. U. per cc., and receive 1—20 cc. vial of the same unitage without extra cost (4 vials in all).

• The quality, potency, and clinical efficacy of Estrogenic Hormones, R & C, and other Reed & Carnrick parenterals have so impressed themselves on physicians that the steadily increasing demand has resulted in significant manufacturing economies. The low list prices of these meritorious products, and the present remarkable BUY 4—PAY FOR 3 offer, reflects these savings. Order now and—ECONOMIZE WITH THE BEST! Offer applies to both multidose vials and boxes of ampuls.

DESCRIPTIVE LITERATURE AND PRICE LIST *ON REQUEST*

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THIAMINE HYDROCHLORIDE
CALCIUM GLUCONATE
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LIVER INJECTION
AMPACOIDS PROSTATE
AMPACOIDS TESTICLE

★ REED & CARNRICK · JERSEY CITY 6, N. J. ★

vasoconstriction in minute

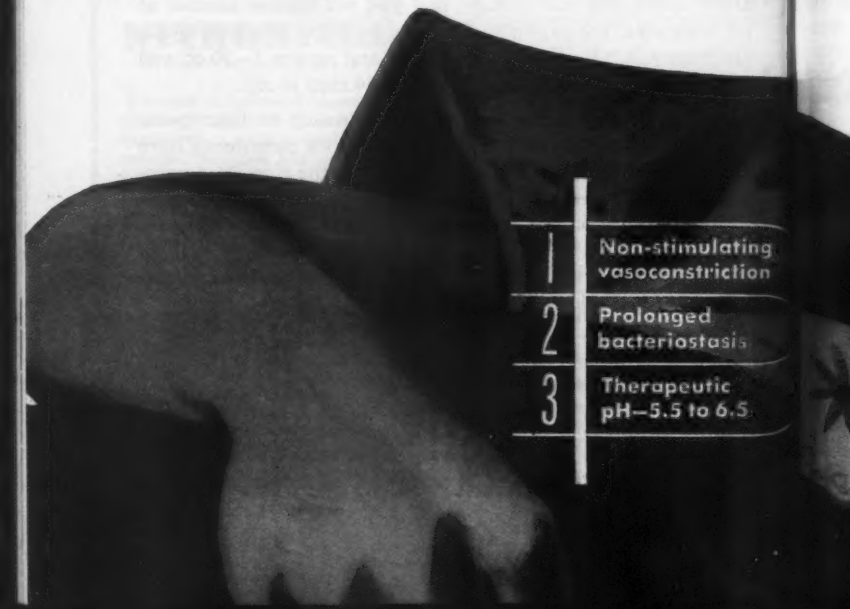
In the treatment of nasal and sinus infections, Paredrine-Sulfathiazole Suspension . . .

1. Affords more rapid, complete and prolonged shrinkage than that produced by ephedrine in equal concentration. Ventilation and drainage are promptly promoted and infected areas are quickly rendered accessible to the sulfathiazole.

2. Provides prolonged bacteriostasis. Paredrine-Sulfathiazole Suspension covers the nasal mucosa with a fine, even frosting of free sulfathiazole, which does not quickly wash away, *but keeps producing bacteriostatic acti hour after hour.* (An objection to solutions of sodium sulfathiazole is the improbability of their remaining in contact with the mucosa long enough to be effective.)

Smith, Kline & French Laboratories—Philadelphia, Pa.

PAREDRINE—SULFATHIAZOL SP



come he would have to accept 14[illegible] office consultations in the thirty-two-hour week he says he work[illegible] which comes to 4 1/3 patients [illegible] hour.

Analyze his declarations any w[illegible] you wish and see if you don't co[illegible] to this conclusion: "Ain't so[illegible] doctors the damndest horn-blowe[illegible] you ever heard?"

M.D., New Yo[illegible]

Solid

Having been born in Consh[illegible] hocken in 1884 and having live[illegible] there half my life, I take exceptio[illegible] to its characterization as a "shant[illegible] town" in your review of the boo[illegible] "Poor Man's Doctor." Long befo[illegible] the nineties, Conshohocken was [illegible] flourishing town, supporting suc[illegible] physicians as Dr. David R. Beave[illegible] famed Army surgeon of the Civi[illegible] War, and Dr. George M. Stiles, one of the outstanding physicians o[illegible] Pennsylvania. Conshohocken also produced such men as Charles He[illegible] ber Clark, the novelist, and Arch[illegible] bishop Thomas L. Kennedy, recto[illegible] of the American College in the Vat[illegible] ican. Shantytown? I think an apolo[illegible] gy is due.

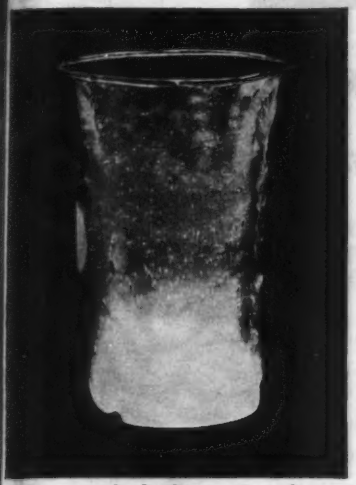
Mrs. Bernard C. Quinn
Bridgeport, Conn.

Conshohocken, like many cities, has its seamy section. The term "shantytown" referred to that section, not to the city as a whole.—ED.

Hurdle

State and national meetings are too specialized. The general practitioner needs more knowledge of such specialties as neurology, pediatrics, pathology, and radiology; but these sections are run solely for the benefit of specialists. Thus the G.P. who drops in rarely gets anything

A DEMONSTRATION THAT



Unretouched photo. Note how Lorophyn Jelly spreads over wall of beaker, forming continuous film.

Lorophyn jelly

has effective occluding properties

A quick office test offers a simple way to visualize the excellence of Lorophyn Jelly (for conception control) in providing effective barrier-action in occluding the os cervix.

Into a glass beaker, squeeze, at the rim, approximately one application of Lorophyn Jelly. Note that Lorophyn Jelly forms a continuous film on the side of the beaker and that it covers a considerable area on the bottom of the beaker. See illustration. This test provides a simple demonstration of the spreading and barrier-action of the Jelly.

In tests, Lorophyn Jelly has killed sperm in less than one minute, even at dilutions as high as 1:20; it is non-toxic, non-irritating.*

*Eastman, N. J., and Scott, A. B.: Human Fertility, 2:33-44.

ACCEPTED AMERICAN MEDICAL ASSN

Accepted by the Council on Pharmacy and Chemistry of the American Medical Association

Active Ingredients. Phenylmercuric Acetate 0.05%, Polyethylene glycol of mono iso octyl phenyl ether 0.3%, Methyl p-Hydroxy Benzoate 0.05%, Sodium Borate 3.0%.

EATON LABORATORIES Inc.
NORWICH, NEW YORK

to

brighten

the

outlook

in

Menstrual Dysfunction

In the management of the depressive symptoms so frequently associated with primary dysmenorrhea, the physician will find Dexedrine Sulfate a valuable aid.

Dexedrine may be depended upon to alleviate apathy, depression of mood, and psychogenic fatigue, and thereby to improve the patient's general mental outlook in this functional disorder.

Smith, Kline & French Laboratories, *Philadelphia, Pa.*

Available in one size only . . . 5 mg.

Dexedrine Sulfate Tablets

(dextro-amphetamine sulfate, S.K.F.)

a

notable

Central

Nervous

Stimulant

of value. More papers on such topics should be presented at the general meetings.

W. W. Horst, M.D.
Wilmington, Calif.

Burned

A good many doctors here—generally through oversight—have been skimping on their fire insurance. When I was burned out recently, however, losing $8,000 worth of equipment that was insured for only $2,000, every physician I know in this town increased his coverage!

M.D., Michigan

Directory

I think a directory of specialists is wrong in principle, since there are as many good ones out of it as in it. A list of such men, prepared by a county medical society, would serve the same purpose—and there would be no fee for getting on it.

M.D., Wisconsin

Certifying doctors in a specialty is unnecessary; it is no assurance that they are better than other doctors and is against free competition. I suggest that each state medical society set up a list of specialists, giving a brief background of each man's experience.

M.D., New York

Clutches

The lot of doctors in general would be improved if each specialist stuck to his last. As it is now—in this section, at least—specialists won't refer patients whose complaints are out of their scope to other, appropriate specialists. So everyone is doing general practice. I am a psychiatrist, but only about 30 per cent of my work is in that

For baby patients, Doctor, you naturally recommend a pure, mild, gentle soap.

We believe Swan has excellent qualifications for the job! It's pure as "100% olive oil" castiles.

Hospital experiments on hundreds of babies reveal that "no soap tested—whether castile or floating soap—is milder than Swan."

Swan's fats and oils are high grade! No free alkali, free fatty acid, coloring matter or strong perfume.

Free!

- A cake of pure Swan to every baby born in the U. S. in 1946!

Tell new mothers to get this gift by writing to Swan, Box 19, New York 8, New York.

SWAN floating soap
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an *exposé* of a basic defect in average milk diets

The *degree* and *extent* in which the milk diets of early infancy are *deficient* in certain B factors is not always fully appreciated.

"... the average breast-fed baby does not receive his requirement of thiamine ..."[1]

"Both human and cow's milk are poor sources of nicotinic acid ..."[2]

"The daily intake (of riboflavin) of the young infant fed only human milk is considerably lower than this estimate of requirement (0.5 mg.), even when the riboflavin content of milk is at its maximum."[1]

White's **MULTI-BETA LIQUID**

is formulated specifically to compensate for these inadequacies, supplying thiamine, riboflavin and nicotinic acid in amounts directly proportionate to their inadequacies, and, in addition, pyridoxine hydrochloride and calcium pantothenate.

FORMULA:

Each cc. (approx. 20 drops) contains:

THIAMINE HYDROCHLORIDE, U.S.P.	2.5 mg.
RIBOFLAVIN	500 micrograms
PYRIDOXINE HYDROCHLORIDE	150 micrograms
CALCIUM PANTOTHENATE	200 micrograms
NICOTINAMIDE	10 mg.

Non-alcoholic. Imparts no odor or taste. May be added to feeding formula or orange juice. Supplied in bottles (with droppers) of 10 cc., 25 cc. and 55 cc., and in 8-oz. dispensing bottles.

IN RESTRICTED ADULT DIETS—such as the Sippy treatment, Karell regime, and others based upon milk, White's Multi-Beta Liquid is a sound, economical supplement. Also of value in tube feeding and when difficulty in swallowing tablets or capsules is encountered.

1. Marriott, W. McK.: Infant Nutrition, revised by Jeans, Mosby, St. Louis, 3rd Edition, 1941.
2. Jeans, P. C.: The Feeding of Healthy Infants and Children, J. A. M. A., *120*: 913, 1942.

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(1) Drop one tablet in 4 cc. water.

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ADAPTED TO BOTH
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(2) drop in 1 cc. urine.

(2) float in 1 cc. urine.

(3) degree of turbidity indicates presence of albumin.

(3) ring density indicates presence of albumin.

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THE "BLACK DOCTOR"

We're proud to add the exotic beau of this rare salmon fly, originated almost a century ago, to the colorful series on Sportsman packages.

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Handsome wood-capped bottles with vivid color reproductions of sports paintings by famous American artists. Shaving Lotion, Cologne, Hairdressing, 4 oz. $1.50; 8 oz. $2.50. Talc, 75c, $1. Shaving Bowls, $1.50 and $2.50. Sportsman Gift Packages $2.25 to $10

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s a rational therapy for coughs in

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4. Whooping Cough 5. Smoker's Cough

The single therapeutic element in Pertussin is an extract of thyme (Process Taeschner) which is quickly absorbed and carried to the secretomotor center. It is highly beneficial in easing cough paroxysms not due to organic disease, because:

1. It stimulates secretion of the tracheobronchial glands to relieve dryness.
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Pertussin is palatable, well tolerated, and free from any undesirable side action. It has been widely prescribed for over 30 years and deserves your recommendation for children, adults and the aged.

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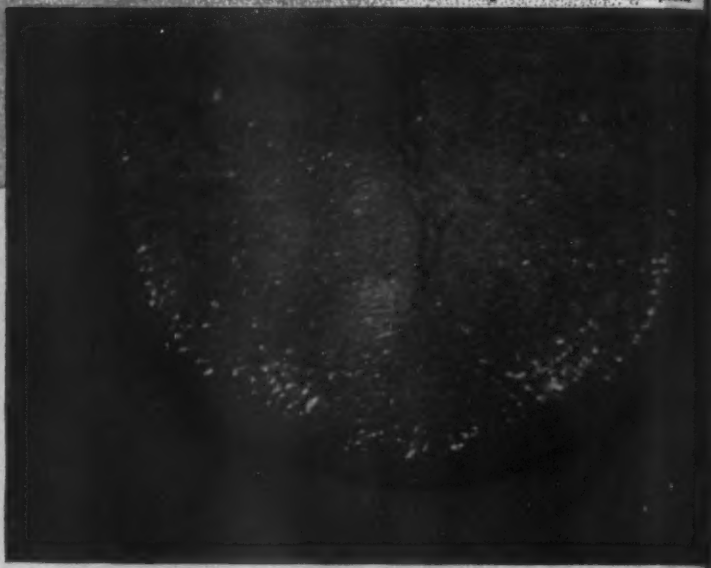

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Each small capsule provides all clinically established vitamins in *amounts substantially greater than adult basic daily requirements,** yet not wastefully in excess of the vitamin needs of the average patient for whom a sound multi-vitamin supplement is indicated.

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**Promulgated in regulations of Food and Drug Administration, 1941*

specialty and practically none of it is referred. Even the surgeons practice psychiatry if a case walks in.

M.D., Virginia

Asset

A circulating library of X-ray negatives showing various stages of malignant growths would be an invaluable asset to physicians in many a U.S. community. How about it?

M.D., Connecticut

Stuck

We need a medical license good throughout the U.S. Lack of one keeps doctors practicing in New York, for instance, when they'd be glad to move to an area where the need is greater and where competition is not so keen.

M.D., New York

Sob

Almost daily, our metropolitan newspapers publish stories of deliveries by firemen, policemen, and street cleaners. More often than not, there is a cut of the proud mother, the baby, and the amateur obstetrician; plus a conclusion to the effect that "The ambulance doctor said he had never seen a better job."

It would appear from all this that maternity care is both an overrated and an overpaid phase of medical practice. EMIC should promptly revise its fee schedule downward.

Meanwhile, mortality rates among mothers and infants will bear looking into, also, for physicians are evidently responsible for most of the current deaths. How could it be otherwise, when one policeman has a record of nineteen deliveries and no losses; another one, eleven hits and no errors?

No movie producer has yet announced a supercolossal feature with a policeman-obstetrician as its hero. But the time will come. Imagine the scene in which Sergeant O'Hara has shot and mortally wounded a hold-up man. The dying youth looks up into his face. "Don't you remember me, Sergeant? I was your thirteenth delivery, back in the forties. My mother has kept the newspaper picture all these years." The sergeant looks hard at the victim, then recognizes him. A tear courses down his red cheek and drops onto the blue uniform.

"To think," he sobs, "that these hands that brought him into the world have now sent him out of it."

This idle daydreaming may not be so idle after all. When socialized medicine comes, there will always be scenario writing.

M.D., New York

Correction

An item in "The Newsvane," October issue, under the heading "Hospitals Rebel," is erroneous in that it gives the impression that the Greater Detroit Hospital Council took action on a resolution that was introduced by an individual hospital administrator at our June meeting. Here are the facts:

A resolution was introduced. But due to the gravity of its charges, no action was taken other than to refer it to a special committee for examination. At the September meeting, following the report of this committee, the council unanimously rejected the resolution because of the many misstatements it contained.

John H. Law, M.D., President
Greater Detroit Hospital Council

Editorial

It's Up to the States

Three meetings of signal importance were held a month ago in Chicago. The first was a two-day session of the AMA Council on Medical Service and Public Relations; second was the Conference of Presidents and other Officers of State Medical Societies; and third, the three-day meeting of the AMA House of Delegates. These gatherings gave major attention to the need of a national, voluntary, prepayment medical care plan.

The council clarified the plan by presenting the half dozen most likely methods of achieving it. The Conference of Presidents gave impetus to the plan by demonstrating that more than half the state medical societies in the country (including practically all the larger ones) are solidly behind it. And the House of Delegates approved the plan, instructing the Board of Trustees and the Council on Medical Service and Public Relations to "proceed as promptly as possible with the development of a specific, national health program, with emphasis upon the nationwide organization of locally administered prepayment medical care plans sponsored by medical societies."

The big question now is: How long will it take to put the plan into operation?

The answer depends on how diligently our local medical organizations will work for the desired end, on how generously they will support it financially, and on how readily they will compromise points of difference during the development of the project.

Fortunately, a good many men in the profession recognize the need of unifying medical prepayment on a national scale and are bending every effort to bring it about. One of their biggest jobs is to convince others of the need.

Encouraging, too, is the promise of financial backing. About $250,000 is reportedly required to launch a national medical plan successfully. Up to last month, when only a handful of medical and hospital service organizations had been solicited, pledges had already been received totaling $200,000.

Despite this late, but fairly auspicious start in the right direction, there's vital work ahead. Find out what your own state medical society is doing to further the national plan mentioned here, and offer your assistance. If the society is doing nothing, goad it into action. This is the only means available by which to defeat the Wagner-Murray-Dingell scheme and to assure a substantially better distribution of medical care.

—H. SHERIDAN BAKETEL, M.D.

AMA Council Busy Developing National Medical Plan

New program offers first real alternative to the Wagner-Murray-Dingell bill

EDITORS' NOTE: The object of the National Medical Plan discussed here and in the editorial on page 39 is to *unite the medical profession* solidly behind the drive to make voluntary health insurance available in every state to every citizen. The aim of the National Health Congress (see page 83) is to *unite industry, labor, agriculture, government, and the professions* in the same drive. Both types of organization are needed. The two should be able to function simultaneously, with benefit to each. They are not competitive, but complementary.

Amid loud applause the AMA House of Delegates last month placed its official imprimatur on a voluntary National Medical Plan which, under professional auspices, would provide adequate care for all the people at a price they could afford to pay. The delegates' reference committee on legislation and public relations had reported as follows:

"Your committee has reviewed several resolutions calling for the adoption of voluntary prepayment medical care plans. All these plans show a uniformity of desire for the setting up of a national plan on a voluntary basis. In all of them the urgency of this being done is stressed.

"Accordingly, the committee recommends that the House of Delegates instruct its Board of Trustees and Council on Medical Service and Public Relations to proceed as promptly as possible with the development of a specific national health program, with emphasis upon the nationwide organization of locally administered prepayment medical plans sponsored by medical societies."

The House of Delegates vote was unanimous—with the result that the Board of Trustees and the Council on Medical Service and Public Relations are now working out the details of putting the National Medical Plan into operation.

Various proposals for a National Medical Plan had been offered at a council meeting just preceding that

of the House of Delegates. There, Dr. Julian Price of South Carolina outlined the organization and operation of a suggested national association of medical service plans. Mr. John R. Mannix recommended an alliance of all medical and hospital prepayment projects, to be known as the American Blue Cross. Dr. Carl M. Peterson of the AMA described an industrial physicians' plan. Mr. C. H. Crownhart of the State Medical Society of Wisconsin explained the "Wisconsin Plan" under which indemnity coverage is provided by a group of commercial insurance companies. Mr. J. A. Hampton indicated what the Continental Casualty Company is offering. Mr. Don C. Hawkins discussed the American Health Insurance Corporation, a $600,000 company which is now licensed in twelve states and which might be bought as a nucleus for a National Medical Plan. Dr. F. L. Feierabend of Kansas and Dr. Frederic E. Elliott of New York gave details of a non-profit, national casualty corporation designed to complement and cooperate with all medical society prepayment plans.

The National Medical Plan, whatever form it takes, will serve primarily to coordinate the activities of all state prepayment plans. States that have no such plans will be urged to develop them; until they do, the National Medical Plan will probably make prepayment coverage available, so that no segment of the population need go without it.

The national body will educate physicians and the public in the functions of voluntary prepayment plans and the need for supporting them. It will facilitate the enrollment in local plans of national enrollment groups. It will encourage increases in benefits as well as the inauguration of new benefits.

The National Medical Plan, as proposed, will have no interest in usurping local plans. On the contrary, its object will be to promote them. It will furnish coverage locally only in states that have no plans and until such time as they organize their own.

The Council on Medical Service and Public Relations holds the following opinions concerning the National Medical Plan: (1) It should be organized as a non-profit stock corporation. (2) It should be chartered in one state and licensed to do business in all the others. (3) It should be under medical control but should be integrated with hospitalization plans. (4) It should be financed by loans without interest from state medical societies and from local and state voluntary prepayment medical plans, to be matched by grants from the AMA. (5) Coverage at first should be limited to surgical and obstetrical types, on an indemnity basis; but, as soon as possible, medical cases should be included also. (6) Local plans should be encouraged to provide a service type contract for veterans and their dependents, for the low-income group, and for those whose medical costs are borne by taxation.

Since it is predicted that each local plan will have to meet minimum standards to qualify for inclusion in the National Medical Plan, and that each will be subject to periodic inspection thereafter, the chance of failure would be slight. If a plan does, however, show signs of weakness, the national body will no doubt

be ready with competent advice and financial support.

Existing medical prepayment plans now *pay claims* anywhere; but they cannot *enroll* subscribers anywhere. The National Medical Plan would obviate that hurdle by making possible national enrollment.

Thus, if the X Company, with employes in all forty-eight states, were to join the national plan, its forty-eight groups of employes would be taken care of by the respective, affiliated local plans. The X Company would be doing business, however, with only one plan, the national one. This is in contrast to the present situation in which the X Company can get employe coverage in only twenty-four states and then only by dealing with twenty-four separate local plans (which it refuses to do).

The National Medical Plan differs from commercial casualty insurance plans in that it will probably (1) be non-profit, (2) be controlled by physicians, (3) furnish broader coverage, and (4) encourage the development of service contracts wherever possible.

An important difference between the Hospital Service Plan Commission of the American Hospital Association and the National Medical Plan is that the commission provides no coverage, being primarily a certifying and coordinating agency, while the medical plan, as now envisioned, *will* provide coverage in those instances where no local program has been set up to do the job.

In cases where a state has no medical prepayment plan and coverage is provided by the National Medical Plan, that coverage, it is said, must be of an indemnity rather than a service type. The reason for this is that a service contract cannot be administered at any great distance from the central office, while an indemnity contract can.

No Holds Barred

I had had only two years of didactic lectures and no clinical experience, but I had gone before our district medical examining board and received my license to practice medicine. Almost immediately I was summoned to attend my first obstetrical case. I had never witnessed a delivery, but had heard of postpartum hemorrhage and of the Crede method for controlling it. Fortunately, the birth was normal. But bleeding naturally followed, and that confounded me. I was so certain my patient was hemorrhaging to death that I grabbed the uterus and held on for dear life. This lasted from 9 at night until 10 the next morning, when my hands were so paralyzed I had to let go.

The mother and baby lived, but the physician nearly died. As compensation, however, a reputation was made: I soon became known as the young doctor who had labored all night to save the life of a mother bleeding to death in childbirth.—M.D., TEXAS

This Year's Federal Income Tax

The new provisions, summarized and interpreted for physicians

The reduced Federal income tax rates that went into effect January 1 this year, will be reflected for the first time in the declaration of estimated 1946 tax, to be filed on or before March 15, 1946. The new rates *do not affect* the final 1945 income tax declaration or payment due January 15, 1946, or the 1945 income tax return due March 15, 1946.

Both the normal tax and surtax remain this year, but with important differences:

NORMAL TAX

In the normal tax, which stays at 3 per cent, the significant change concerns the exemptions permitted. Heretofore you could take only one $500 exemption against your net income when figuring the normal tax, regardless of marital or dependency status. Thus, in 1945, a doctor with a $7,000 net income took a $500 exemption and computed his normal tax at 3 per cent of $6,500, or $195. The fact that he was married and had two dependent children, for example, did not count. In 1946, he may take a $500 exemption not only for himself, but also for his spouse and for each of his two dependent children. He then subtracts these exemptions aggregating $2,000 from his $7,000 net income and arrives at $5,000 as the basis for computing his normal tax at 3 per cent. The resultant $150 is called his "tentative normal tax."

SURTAX

The lowest surtax rate for 1945 was 20 per cent, applicable to the first $2,000 of surtax net income. In 1946 surtax rates begin at 17 per cent and a corresponding cut of three percentage points is made in every surtax bracket.

The surtax net income in 1946 is the same as the amount on which the normal tax is computed. Moreover, it is arrived at in the same way: by subtracting the total of the exemptions from net income. Thus in the case of the married physician with a $7,000 net income and two dependent children, surtax net income is $7,000 less $2,000 for the four exemptions, or $5,000. To this surtax net income the following surtax rates apply:

17% on the first $2,000	$340
19% on the second $2,000	380
23% on the $1,000 excess over $4,000	230
Tentative surtax	$950

5% 'DISCOUNT'

The tentative normal tax and the tentative surtax are so called because still another step is to be taken before the final tax is arrived at. The tentative normal tax, computed for the doctor above at $150, is added to his tentative surtax of $950. The resulting sum of $1,100

might be called the "tentative total tax," for by a brand new wrinkle in the law the doctor is entitled to reduce this tentative total by "5 per centum thereof." That gives him a reduction of $55 from the $1,100, making his final tax $1,045.

What the new income tax formula means to the practitioner who earns every dollar through professional service is apparent from the fact that in 1945 a doctor earning $7,000 net and having a wife and two dependent children paid a total tax of $1,295. In 1946 he pays $250 less, for a saving of almost 20 per cent.

OPTIONAL PAYMENT

A physician whose adjusted gross income is less than $5,000 has the option of either computing his normal tax and surtax in the manner described or paying his tax according to an "optional tax table." (His adjusted gross income would normally be his total receipts less his operating expenses.)

In calculating net income for purposes of normal tax and surtax, the practitioner may deduct local taxes and other permissible items. If he uses the optional table he simply locates his adjusted gross income in the table and finds the corresponding tax figure in the column designating the number of exemptions to which he is entitled. The tax figures in the table reflect the number

"TALK INTO THE THING, PAW. I GUESS THE DOCTOR IS HARD O' HEARIN'."

of exemptions, the normal tax and surtax rates, and the 5 per cent "discount." They also allow for deductions amounting in round figures to 10 per cent.

Anyone whose adjusted gross income is less than $5,000 will do well to work out his income tax the "long" way and compare the result with the amount shown in the optional table. He has the legal right to choose whichever method is cheaper for him.

MEDICAL OFFICERS' TAX

Doctors in the armed services during the war are given special income tax advantages: They may exclude from taxable income $1,500 of service pay received in any taxable war year beginning after December 31, 1942. Since these provisions affect service pay received during the war, it's worth noting that the war does not end legally until the President so proclaims. Service men are allowed until the end of 1946 to file claims for refunds of overpayment of 1941 and 1942 taxes.

Liberal extensions of time are provided for the payment of income tax on the non-exempt portion of the pay of commissioned officers for the years 1940 to 1946 and on pre-service income earned in 1940 and 1941.

Such unpaid taxes may be remitted in quarterly installments over three years, provided special application is made first to the Commissioner of Internal Revenue. The first installment must be paid May 15, 1946, by men released from the service before December 1, 1945. In all other cases, the first installment must be paid on June 15, 1947, or on the fifteenth day of the sixth month after the date of release from active duty, whichever date comes earlier.

Handitip

Fahrenheit to Centigrade

To convert from degrees Fahrenheit to degrees Centigrade, subtract 32 from degrees F. and divide by 1.8. Conversely, to convert from C. to F., multiply by 1.8 and add 32.

WITHHOLDING TAX

Although the medical man is usually obligated, like other employers, to withhold income tax from the salaries of his office personnel, there are some instances in which the tax need not be withheld at all. For example:

The new withholding tables, effective January 1, 1946, show that an employe who claims two exemptions is not subject to withholding unless his or her weekly pay is $22 or more. Similarly, no tax need be withheld from an employe who claims three exemptions, unless he or she is earning at least $32 per week.

In general, the amount to be withheld in 1946 will be less than heretofore because the withholding tables reflect the lowered income tax rates. You have a choice of withholding the tax on your employes' pay either under the new tables or under a simplified percentage method. The Federal social security rate of 1 per cent each from employer and employe continues throughout 1946.

The use tax on motor vehicles and boats is repealed as of July 1, 1946. Reduction of wartime excise taxes must await the official and legal conclusion of the war.

—HUGH BRUCE, LL.B.

Better Letters . . .

A few hints for medical secretaries

Before writing any letter, ask yourself:

1. What is my real objective?
2. What is the best way to accomplish it? (Consider *all* the alternatives.)
3. What facts, ideas, and impressions must I convey? (Jot them down first on scratch paper if the letter promises to be complicated.)

The beginning of the letter should:

1. Be conventional—not stereotyped.
2. Express the "you" attitude (approach matter from standpoint of the other person's wants and interests).
3. Contain a worthwhile idea (not merely an acknowledgment of a previous letter).
4. Sound a positive tone—never a negative one.

The close of the letter should:

1. Suggest the specific action desired (if any).
2. Express confidence—not merely hope or anticipation.
3. Be stated positively so as to induce the necessary response.

After writing a letter, challenge yourself thus:

1. The letter fails to bear the stamp of one ruling idea. (It can't be summed up in a sentence.)
2. One or more essential points are lacking. (Bear in mind here the response desired.)
3. Non-essential material has been included which is extraneous to the central theme.
4. The ideas are not in logical sequence, nor are they clearly connected.
5. The chief thoughts have been subordinated, the lesser thoughts emphasized.
6. The letter isn't cordial enough.
7. The person's request (if any) isn't adequately answered; so the reply will create dissatisfaction.
8. The writer has overlooked the necessity of putting himself in the shoes of the reader.

A Check-List of Professional Income Tax Deductions

Special attention to these items will reduce your Federal tax bill*

The physician's greatest opportunity for tax savings lies in the many special deductions permitted him. The following list covers every important professional deduction permissible under the income tax law:

Accounting expenses—including amount paid for bookkeeping, preparation of tax returns, auditing of books generally; also cost of determining damages in a lawsuit.

Attorneys' fees and other litigation expenses in defending a suit in connection with your practice.

Automobile upkeep—full cost if automobile is used only for professional calls, or if other use is merely incidental; no part of cost if use is solely for transportation between home and office; proportionate cost if part of use is non-professional. When permitted as a deduction, automobile upkeep includes chauffeur's salary and uniform; depreciation; repairs; tolls; towing; garage rent; interest charges; gasoline; oil; insurance premiums (fire, theft, collision, liability, etc.); greasing; lubrication; license fees; loss or damage not covered by insurance; loss on actual sale of automobile, with depreciation considered; Federal auto use tax (the $5 stamp); tires and tire repair; tire inspection fees; automobile inspection fees; parking charges; AAA or auto club dues.

Bad debts arising from business loans or from services performed if previously reported as income.

Business expenses in connection with any source of income other than practice. Includes cost of maintaining real estate held for investment, also custodian fees paid to banks.

Club dues and expense, if they are necessary to maintain business contacts. These include dues in service clubs, chambers of commerce, etc., provided such membership is for professional purposes. (You must itemize amounts and name organizations.)

Collection expenses incurred in collecting professional accounts. Attorney's fees and other costs are included.

Contributions (up to 15 per cent of adjusted gross income) to charitable, educational, literary, religious, scientific, and other organizations which operate in the manner prescribed by law. Contributions need not be made in cash to be deductible; if property or securities are given, deduct their market value.

Convention expenses, including

*Remember also to make other, non-professional deductions that are available to all taxpayers, e.g., state income and property taxes, alimony, some state taxes on gasoline used for non-occupational driving, state and municipal sales taxes, bad debts arising from personal loans, etc.

transportation to and from meetings, hotel rooms, meals, drinks, telephone calls, tips, etc.

Credit bureau memberships.

Damages, in excess of insurance collected, to property as a result of theft or casualty—*e.g.*, fire, shipwreck, storm, hurricane, drought, collapse of building (but not damage by termites), and freezing. Also, damages paid as a result of a civil suit against you as a physician.

Depreciation on all your professional property, including automobiles, instruments, equipment, furniture and fixtures, or any other asset having a useful life of more than a year. (See "Don't Underestimate Depreciation," this issue.)

Entertainment costs incurred to benefit your practice. These include transportation, meals, drinks, flowers, theatre tickets, admission to games, etc.

Equipment and supplies—books, furniture, and professional equipment used in your office or otherwise in your profession, the life of which is one year or less. (If life is more than one year, see *Depreciation.*) Also rental of equipment necessary to practice.

Gifts—if made to benefit your practice, including candy, cigars, flowers, etc. (See *Entertainment.*)

Insurance premiums on policies in connection with your profession, *e.g.*, those covering accident, burglary, public liability, fire, storm, or theft; also indemnity bonds on employes.

Interest on loans and mortgages. On installment contracts interest is deductible only if it appears as a separate item.

Licenses or similar fees incurred as a physician; also the license for your car.

Losses not covered by insurance, arising from damage to automobile, home, or other property as a result of accident, fire, ice, flood; etc.; loans not repaid; embezzlement; securities sold or exchanged; theft; transactions entered into for profit even though not connected with your medical practice.

Maintenance costs in full, on buildings or real estate used entirely as your office (proportionate cost if only part of the property is used for office and part for your home). Full maintenance cost if property is held for investment or rented to others. Includes such items as taxes on the property; commissions paid to secure the rental; maintenance expenses in connection with property, such as heating, lighting, water, and the cost of other facilities and services; repairs, painting, decorating; salaries and wages paid to janitors, elevator men, and other employes engaged in maintenance of the building; expenses in connection with dispossession of tenants; payroll taxes; depreciation.

Medical journals and books, if of temporary value within the taxable year.

Medical society dues.

Medical supplies (dressings, drugs, vaccines, etc.) consumed within the year.

Moving expenses in connection with your practice.

Rent—see Office upkeep.

Repairs to your office, including costs of decorating, painting, patching, alteration (other than permanent improvement); putting property in safe and efficient operating condition; remodeling; new surfacing; repairs to roofs; repairs necessitated by a casualty, such as explosions, fire, or hurricane (not includ-

ing capital restoration). Also covers repairs to office equipment.

Salaries paid to secretaries, substitutes, and other professional aides and consultants. Also the Social Security taxes (not employes' share) you pay on such salaries. If an employe devotes only part of his full services to your professional establishment, deduct a proportionate part of his wage.

Stationery and supplies used in practice, including bills, cards, and envelopes; labels, letterheads, and printed forms; inks; postage; etc.

Taxes on real estate, personal property, sales, gasoline (certain states only), state and local income taxes, poll taxes, and some state liquor, cigarette, and use taxes. Not deductible are Federal income taxes; gift, estate, and legacy taxes; and Federal excise taxes that have been paid by the manufacturer or wholesaler. (These Federal taxes, formerly deductible in personal transactions, are now deductible only if incurred in the production or collection of income: admissions; automobile use; bond transfer stamp; cable messages; customs and import duties; deed stamp; dues; initiation fees; property transportation; radio messages; safe deposit boxes; stock transfer stamp; telephone and telegraph messages; telephone service, local; transportation of persons; wire and equipment services.)

Telegraph and telephone expenses incurred professionally.

Traveling expenses to conventions affecting your practice, including baggage transfers, lodgings, meals, Pullman and railroad fares, plane fares, boat fares, telegrams, telephone bills, and tips.

Get That Message!

That telephone! It's a cheerful cash register, ringing out a two-dollar slip. It's a thief in the night, sabotaging your sleep. It tolls the doom of long-planned recreation. But you *can* get along with it.

Years ago the phone and I came to an arbitrated peace. Although I made most of the concessions, at least it *is* a peace, and I can now take most demands in my stride.

In the beginning, I would get so excited that I'd forget to ask the name of the patient or the address or the nature of the case. I would chase the doctor to see Mrs. Morris across the city when the call was for a Mrs. Morris two blocks away. I would pluck my hero out of a medical conference for a child screaming with pain from a dog bite, only to find the skin had not been punctured and marks were scarcely visible.

In later years it has been different. I now have a routine that works well not only for me but also [*Continued next page*]

for the doctor's secretary: "Dr. Cummings' office," I try to say in a clear, bright voice (even at 1 A.M.). To the unvarying request to speak to the doctor, I reply, "He is not in; may I take the message?" or "The doctor is busy; may I take the message?"

Nine times out of ten, the person calling answers, "This is Mr. (or Mrs.) John Q. Public," and will want the doctor to see the patient as soon as possible. At that point it is essential to get the right name, correctly spelled, and the street and number. If the patient is a new one, get his phone number. It also makes the doctor's work easier if he knows the needs of the patient, so he can be prepared for anything unusual.

The one call in ten that does not fit this pattern is the one that demands special tact, calmness, and concentration: A frantic woman on the phone babbles incoherently that her husband has had a heart attack. In her anxiety, she shouts a number and street and begs that the doctor come immediately. It helps her, as well as the doctor, if you can answer quietly and firmly. Assure her that the doctor will be there soon. And get the necessary information!

Often, in my inexperienced days, I had calls turn out like this:

"Please send the doctor right over to 1095 Goodman Street; my mother has had a stroke and is lying on the floor unconscious," a sobbing woman implored me. Moved by her evident distress, I neglected to ask her name. By the time I had gathered my wits to do so, she had hung up. Then the trouble began. Was it North or South Goodman Street? The doctor rushed to South Goodman Street and was unable to find number 1095. He then raced to 1095 North Goodman Street, a large apartment house, where he rang for the superintendent and learned, after several minutes delay, that an ambulance had just left with the patient.

When the doctor is in the office, most people want to ask him, personally, to make a call or give them an appointment. This takes both time and energy which the doctor must conserve for the treatment of his cases. If he is busy or not in, people will usually leave their messages after a little persuasion and explanation. This routine sounds so simple that it is almost bromidic. But sugary voices do not help a patient if the message is incomplete.

"Doctor is not in; I'm sorry," one girl who had a voice with a smile used to answer, and firmly put the phone on the hook. Her manner was pleasant and she was a fine stenographer, but she never learned that when a patient calls he wants to reach the doctor, either directly or via a message. More than that—the doctor wants the patient. No matter how busy or how tired he is, he feels responsible for his patients and wants to do as much as possible for as many as possible.

So make friends with your phone. Develop a routine. Keep calm. And *get that message!*—GENE CUMMINGS

Miss Dix Tells All

"Dorothy Dix says: Successful marriage isn't luck; it's the result of congenial testes."—PITTSBURGH POST-GAZETTE

Delegates, in Dynamic Meeting, Set Important New AMA Policies

National medical plan and General Practice Section approved; super-EMIC rejected

Leaving Chicago last month, many a physician carried with him the impression that he had attended one of the most vital, constructive meetings ever held by the House of Delegates. Getting right to the point, the House had formulated and approved new policies which marked a vast forward step for organized medicine.

The most important and far-reaching action was the unanimous adoption of a proposal to create a national medical plan designed to provide voluntary sickness insurance for all Americans at a cost within their means. (See "AMA Council Busy Developing National Medical Plan," this issue.)

The House also approved the following:

¶ Donation of all Government medical surpluses in the Philippines to the islands' hospitals and medical societies and to the University of the Philippines.

¶ Establishment of a permanent Bureau of Information at AMA headquarters to furnish data about possible locations to AMA members.

¶ Organization of a new Section on General Practice, long recommended by this magazine and by medical associations in Michigan, New York, and elsewhere.

¶ The holding of an International Congress on Tropical Medicine, to be sponsored by the AMA and the American Academy of Tropical Medicine, with invitations to be sent out by the State Department.

¶ Placing the National Research Foundation, proposed by Dr. Vannevar Bush, under the control of a board of directors composed of scientists (as provided in the Magnuson bill) rather than under a single director (as provided in the Kilgore bill).

¶ Development of a government program to provide compensation for loss of earnings during illness.

¶ Transfer of the Children's Bureau from the Department of Labor to the Public Health Service.

¶ Grouping of all Government health agencies under a single cabinet head.

¶ A warning to physicians not to telephone narcotic prescriptions except in real emergencies.

¶ Utilization of competent public relations programs on both a national and local scale.

The House disapproved the following:

¶ Senator Claude Pepper's Super-EMIC program which would authorize the Children's Bureau to provide free medical care for every U.S. child under 21 and for every

U.S. woman during pregnancy.

¶ Those portions of the Wagner-Murray-Dingell bill which would have the effect of socializing medicine.

The delegates listened to a resolution proposing that any graduate of an approved medical school who has been honorably discharged from the armed forces and is otherwise qualified be offered a license without examination in any state, and that a recommendation to that effect be sent to all Governors and state licensing boards. The proposal failed to win the support of the reference committee which considered it. Licensure, said the committee, is a state right and the House of Delegates could not with propriety approve the recommendation suggested. To an alternative proposal that each state be asked to grant temporary licenses to properly qualified medical veterans, the committee was also opposed. Doing this, it said, would require changes in licensure laws from coast to coast, and most state medical associations don't want their local licensure laws "fiddled with."

As at previous meetings of the House, resolutions were introduced seeking to curb the extracurricular activities of full-time AMA employes and to prevent them from speaking as the voice of organized medicine unless specifically authorized to do so. Dr. Walter W. Fenton of the California Medical Association presented these resolutions to the House, whereupon the Speaker suggested that they be referred without reading to the appropriate committee. Dr. Fenton declined the suggestion and read the resolutions in full. Later, when they were placed before the House for a vote, sixty delegates supported them and 106 opposed them.

The first of the resolutions read as follows:

"Whereas, the American Medical Association has created a council on public relations, known as the Council on Medical Service and Public Relations, which is charged with the responsibility of representing the American Medical Association to the public and to governmental agencies of the United States; and

"Whereas, the presentation of the official point of view of the American Medical Association by other councils, committees, and individuals leads but to confusion and to different and divergent views, with the effect of apparent disunity of the profession; and

"Whereas, at this time the profession is in need of greater unity than ever before in its history; therefore, be it

"Resolved, that the council on Medical Service and Public Relations shall be the sole agency for presentation of the attitude of the American Medical Association relative to matters in which the organized profession should or must make representation to the public or to the Government."

The second resolution was worded thus:

"Whereas, the American Medical Association is in need of the most efficient organization possible in the solution of its problems; and

"Whereas, employes who participate in activities outside the organization cannot render their best service to the association; therefore, be it

"Resolved, that all employes of the Association, who are not spe-

cally employed on a part-time basis, shall be required to devote their full time to the activities of the Association for which they are employed and not engage in outside activities from which they derive financial income."

There was enthusiastic praise among the delegates for Maj. Gen. Paul R. Hawley following an address in which he explained the Veterans Administration's radically new approach to the problem of adequate medical care for ex-servicemen, including a plan which would encompass the services of private practitioners (see "Hawley Would Expand Plans," this issue). The V.A.'s new concepts of service, as well as General Hawley's personal attitude, were commended as being in the best interests of the public and the profession. Warmly applauded was his statement: "I'm just as interested as you are in keeping the Government out of medicine."

Dr. Roger I. Lee, Boston, was inducted into office as the new president of the Association, while Dr. Harrison H. Shoulders, Nashville, Speaker of the House of Delegates, was named president-elect. Elected to the Board of Trustees were Drs. John H. Fitzgibbon, Oregon; Dwight Murray, California, and James R. Miller, Connecticut. Maj. Gen. George S. Lull, deputy surgeon general of the Army, was slated to succeed Dr. Olin West as AMA secretary and general manager after serving an indoctrination period as Dr. West's assistant.

Among some of the points made by Dr. Lee in his inaugural address:

"Perhaps the most common adverse comment on the House of Delegates, and indeed on the American Medical Association, relates to what is called insufficient infusion of younger men, of young blood into the House of Delegates. As I have said, the remedy does not lie in the House but in the constituent associations. . .

"Since regular sessions of the House are held only annually in normal times, the suggestion is often heard that an additional and presumably a midwinter meeting—be held. As I see it, the chief advantage would be in timing. For example, the meetings of some state medical societies may be held just before, just after, or even during the annual meeting of the House. Under those conditions, any business proposed by a state medical society for action by the House of necessity lies over for a year. I am inclined to think a midwinter session would help relationships with the constituent associations and would perhaps permit previous publication of business and opportunity for more careful study. . .

"At the present time, some of the councils, committees, and bureaus are grievously handicapped by inability to secure competent personnel. It is to be hoped that the cessation of hostilities will make possible, for example, the reconstruction of the Bureau of Medical Economics."

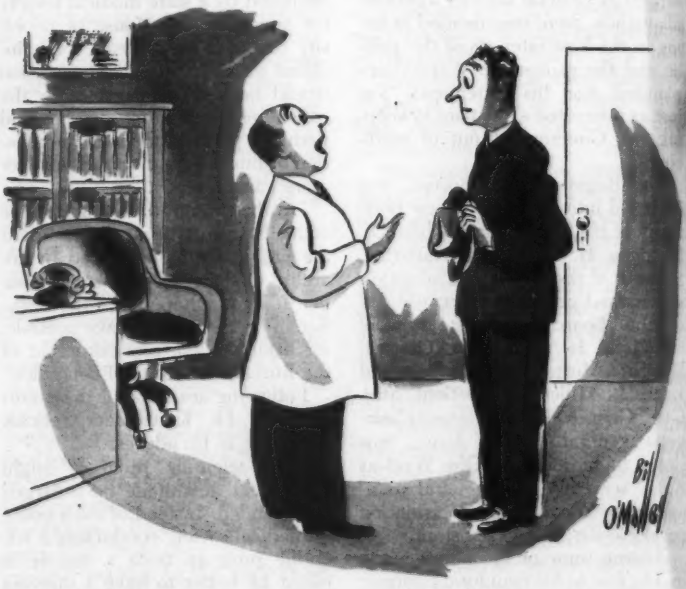
Following are some of the points made by Dr. Kretschmer, retiring president, in his address:

"The scientific program might with great advantage be enlarged or expanded. Instead of each county medical society conducting a scientific program once a month, it might be better to have a meeting of six, eight, or ten adjoining counties. Then the program could be arranged as an all day and evening

meeting. This would insure a larger gathering, better speakers, and a better coordinated program. It could be planned to cover many topics and they could be presented from a post-graduate point of view.

"The regular organizational meetings of the county medical society could then be devoted to such problems as ethics, economics, and organization. With this rearrangement, some meetings should be devoted to the interests of the public, with timely educational topics presented to a lay audience. Moreover, meetings could be held in association with the social service, relief, political, public health, and similar groups. Here the position of the medical profession on many of the present-day controversial problems could be presented to the laity."

Discussing returning medical officers, Dr. Kretschmer said: "Their difficulties in obtaining hospital appointments is something that deserves your earnest consideration. In many hospitals, the privilege of being a member of the staff or the privilege of bringing patients to the hospital is contingent on membership in the county medical society. In some places, returning medical officers have been placed on probation for one or two years. This practically closes the doors of the hospitals to them. It is unwarranted, unfair, and un-American."



"SO IT'S ESSENTIAL THAT YOU MOVE TO A WARMER CLIMATE FOR A YEAR. DO YOU WANT TO RENT YOUR HOUSE?"

Considering a Specialty?

Some of the things to think about in deciding and in getting started

You may have asked yourself these questions: "What is my real reason for wanting to enter a specialty—a particular specialty? Have I the talent, the capacity, to make a go of it; or have I been influenced unconsciously by the concomitants: prestige, superior income, etc.?"

In addition, you may have weighed these factors: (1) in some localities your chosen field is overcrowded; (2) not all specialties, and certainly not all specialists, are high on the income scale; (3) the general practitioner is closer to his patients and to the community than the specialist is, and, according to some, he is gaining new stature with the developing interest in psychosomatic medicine.

But there are still other considerations. Here are some of them:

SUPPLY, DEMAND

Specialist strength throughout the nation (as of 1942) is shown in Table 1. Unfortunately, it is no index whatever to the demand, nor does any such index exist. After you have made a tentative choice of the community in which you plan to specialize, you will have to do your own spadework among its G.P.'s to determine the prospects.

In gauging future demand, consider the constantly changing pattern of practice. Geriatrics, for example—as well as cardiology and cancerology—show every indication of becoming busier fields as the population continues to age. Pediatrics, too, may benefit to some degree from the growing demand for more and better school-health services. And a nation-wide hospital construction program is almost certain to mean a demand for pathologists, roentgenologists, staff surgeons, and anesthetists.

Probably the greatest demand today is for neuropsychiatrists. Yet they have long been among the poorest paid of all specialists, with an average gross income in 1943 below that of the general practitioner.

INCOME

The average gross income of full specialists in 1943 was $18,367, according to the Fifth MEDICAL ECONOMICS Survey. Of that amount, an average of 33 per cent was paid out in the form of professional expenses. By contrast, general practitioners earned an average of $12,554, of which 36 per cent went out in expenses. Table 2 shows gross income according to specialty for 1943, 1939, and 1935.

In the matter of hours worked and number of patients seen daily, specialists and G.P.'s are about on a par. In 1943, full specialists averaged 9.9 hours a day; partial specialists, 11.7 hours; G.P.'s, 11.4 hours. Full specialists saw an average of

23.9 patients daily; partial specialists, 26.5; and G.P.'s, 23.5.

CERTIFICATION

Even though a specialist may of course practice without specialty board certification, the trend among younger men toward such certification is now so pronounced that some

Table 1
NUMBER OF SPECIALISTS IN PRACTICE, BY SPECIALTY, 1942

	All Specialists	Full Specialists	Partial Specialists	Diplomates
All specialties	65,428	39,423	26,005	18,658
Allergy	373	152	221	44
Anesthesia	914	339	575	176
Bacteriology	85	61	24	6
Cardiology	634	166	468	131
Clinical Pathology	426	302	124	208
Dermatology	1,489	1,071	418	573
Gastroenterology	342	119	223	63
Gynecology	1,123	268	855	104
Industrial Practice	1,870	541	1,329	5
Internal Medicine	6,378	6,378	..	2,489
Neurology	149	81	68	45
Neurology and Psychiatry	1,911	1,536	375	786
Neurological Surgery	157	146	11	106
Obstetrics	2,412	294	2,118	95
Obstetrics and Gynecology	4,683	2,319	2,364	1,364
Ophthalmology	2,115	1,659	456	1,178
Ophthalmology, Otology, Laryngology, Rhinology	4,964	4,256	708	1,735
Otology, Laryngology, Rhinology	2,124	1,697	427	1,335
Orthopedic Surgery	1,543	1,180	363	808
Pathology	909	694	215	562
Pediatrics	4,658	2,673	1,985	1,842
Plastic Surgery	120	90	30	66
Proctology	806	344	462	88
Psychiatry	1,295	1,025	270	447
Public Health	1,767	1,767	..	25
Radiology and Roentgenology	2,564	1,698	866	1,431
Surgery	15,719	6,270	9,449	1,993
Tuberculosis	1,306	614	692	105
Urology	2,592	1,683	909	848

Source: American Medical Association.

the boards face the possibility of having too many applicants in the years just ahead. Meanwhile, more and more emphasis is being placed upon certification: Many hospitals, industrial clinics, and private groups require it for staff membership; and it is considered probable that health insurance programs may in the future authorize specialist fees only for the certified.

Thus, though it confers no legal rights, a board certificate is by far the most widely accepted mark of qualification. Nevertheless, it is often pointed out that lack of one has not been a serious handicap to some specialists; that, in the long run, a man's standing among his general practitioner colleagues and among his patients constitutes an effective endorsement of his ability.

Examination fees of the various boards range from $30 to $100. Information about such things as credit for military service and eligibility requirements may be obtained from each board. A list of them, with names and addresses of their secretaries, follows this article.

GETTING STARTED

Availability of post-graduate specialty training will be discussed in another article in this series. Meanwhile, lists of courses and information about residencies may be obtained from medical schools, from hospitals, and from the AMA Council on Medical Education and Hospitals, 535 North Dearborn Street, Chicago 10, Ill.

An assistantship to an established

Table 2
AVERAGE GROSS INCOMES OF FULL SPECIALISTS, BY SPECIALTY

Type of Practice	1943	1939	1935
All physicians[1]	$14,341	$ 7,365	$ 6,139
Full specialists	$18,367	$10,057	$ 8,446
Obstetrics-gynecology	22,219	9,273	8,158
Surgery	20,733	12,161	10,149
Roentgenology	20,358	13,534	12,128
Pediatrics	20,044	8,018	6,638
OALR	19,180	11,310	7,747
ALR	17,538	9,879	7,645
Urology	17,488	9,299	7,143
Dermatology	15,641	8,919	7,774
Ophthalmology	15,547	11,089	8,234
Internal medicine	15,046	10,655	8,947
Neuropsychiatry	9,921	7,451	8,076
General practitioners	*12,554*	*6,605*	*5,068*

[1]Active, civilian, non-salaried physicians (i.e., those who derived less than 50 per cent of their income from salaries).
Source: Fifth MEDICAL ECONOMICS Survey.

specialist does not, of course, obviate the need for post-graduate study, but it *is* another door to specialism and it *has* its advantages: (1) It offers the greatest degree of security for the immediate future; (2) it requires the least investment; and (3) it gives one the "feel" of private practice. Usually, too, it leads to desirable contacts both inside and outside the profession. Its main drawback is likely to be psychological: a feeling of inferiority in being identified as "the assistant."

Those who have entered specialism from general practice insist that they are better specialists for having done so. Such a program should have special appeal to medical veterans, inasmuch as it insures income during the training period. Interruptions for post-graduate courses must, however, be anticipated.

The usual approach is to apply to one's hospital for appointment to the appropriate clinic service. There, in lieu of fees, the initiate will have the opportunity to work regularly in his specialty, to enrich his contacts. Also, he will acquire a title—and thereby a certain authority for papers and talks.

In conjunction with his clinic work (and with his private practice as he begins to take on specialty cases), let the beginner keep records of treatment methods, findings, and results. From these, he will be well advised to prepare reports on interesting cases or aspects of his work, and let his staff chief—as well as the secretary of his medical society—know that such reports are available for presentation.

Assume, for example, that you are working in a neurological clinic. By the time you have seen a goodly number of epileptics, your records may show a worthwhile comparison between the values of dilatin and phenobarbital. The hospital, because the work has been done in its clinic, may be able to obtain desirable recognition if you release your data to the institution in the form of a report. Thus you also consolidate your institutional standing.

CONTACTS

Because the specialist's position is quite different from that of the G.P. in the matter of getting known, he is naturally inclined to focus his social activities on contacts with other doctors. His "club" is likely to be the staff room of his hospital—where, incidentally, shop talk is always welcome. And if his county medical society has a welfare committee in his specialty, it will pay him to ask to be assigned to it. If no such committee exists, he may be able to stimulate interest in forming one.

If there is a state society in his specialty, he should by all means join it. Likewise, it is important to give due consideration to those social agencies that impinge upon the specialty. A pediatrician, for example, might associate himself with children's aid societies, orphanages, or societies for the prevention of cruelty to children. Organizations exist for helping the blind, the deaf, the crippled, and the aged. Numerous nonmedical agencies are interested in cancer, tuberculosis, maternal welfare, venereal disease, alcoholism, mental hygiene, nutrition, public health, infantile paralysis, and rehabilitation. Doctors as a whole tend to ignore these agencies, despite the opportunities they offer him to expand his professional experience and personal contacts.

Though local customs vary, use

of the word "specialist" on stationery, visiting cards, and office signs is generally frowned upon. But the phrase, "Practice limited to . . . ," is usually acceptable. In some places, specialists may be listed as such in the telephone directory. If you have any doubt about local "ground rules," consult your county medical society.

—A. G. ROSS

Address your inquiries to American boards as follows: **Anesthesia:** Dr. Paul M. Wood, American Board of Anesthesiology, 131 Riverside Drive, New York 24, N.Y. **Dermatology:** Dr. George M. Lewis, American Board of Dermatology and Syphilology, 66 East 66th Street, New York 21, N.Y. **Gynecology:** Dr. Paul Titus, American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pa. **Internal Medicine:** Dr. William A. Werrell, American Board of Internal Medicine, 1 West Main Street, Madison 3, Wis. **Laryngology:** Dr. Dean M. Lierle, American Board of Otolaryngology, University Hospitals, Iowa City, Iowa. **Neurology:** Dr. Walter Freeman, American Board of Psychiatry and Neurology, 1028 Connecticut Avenue, Washington, D.C. **Neurosurgery:** Dr. Paul C. Bucy, American Board of Neurological Surgery, 912 South Wood Street, Chicago 12, Ill. **Obstetrics:** Dr. Paul Titus, American Board of Obstetrics and Gynecology, 1015 Highland Building, Pittsburgh 6, Pa. **Ophthalmology:** Dr. S. J. Beach, American Board of Ophthalmology, 56 Ivie Road, Cape-Cottage, Me. **Orthopedics:** Dr. Guy A. Caldwell, American Board of Orthopedic Surgery, 3503 Prytania Street, New Orleans 15, La. **Otology:** Dr. Dean M. Lierle, American Board of Otolaryngology, University Hospitals, Iowa City, Iowa. **Pathology:** Dr. F. W. Hartman, American Board of Pathology, Henry Ford Hospital, Detroit 2, Mich. **Pediatrics:** Dr. C. A. Aldrich, American Board of Pediatrics, 115½ First Avenue, S.W., Rochester, Minn. **Plastic Surgery:** Dr. James B. Brown, American Board of Plastic Surgery, 608 North Grand Boulevard, St. Louis, Mo. **Psychiatry:** Dr. Walter Freeman, American Board of Psychiatry and Neurology, 1028 Connecticut Avenue, Washington, D.C. **Radiology:** Dr. Byrl R. Kirklin, American Board of Radiology, Mayo Clinic, Rochester, Minn. **Syphilology:** Dr. George M. Lewis, American Board of Dermatology and Syphilology, 66 East 66th Street, New York 21, N.Y. **Surgery:** Dr. J. S. Rodman, American Board of Surgery, 225 South 15th Street, Philadelphia, Pa. **Urology:** Dr. Gilbert J. Thomas, American Board of Urology, 9622 Brighton Way, Beverly Hills, Calif. **X-Ray:** Dr. Byrl R. Kirklin, American Board of Radiology, Mayo Clinic, Rochester, Minn.

"HE SAYS YOU GOT TO HAVE AN APPOINTMENT TO SEE HIM, TOO!"

Don't Underestimate Depreciation On Your Income Tax Return

Here's an approved way of determining wear, tear, and obsolescence

The Fifth MEDICAL ECONOMICS Survey indicated that the investment in equipment of the average non-salaried physician in 1943 was $4,658. When you add the cost of his car, that part of his home used as professional quarters, his office furniture, and his medical library, it becomes evident that the loss through depreciation is not inconsiderable. And since depreciation is deductible tax-wise as a cost of practice, you will be repaid if you compute it adequately.

The Bureau of Internal Revenue, speaking of depreciation, says, "The proper allowance for exhaustion, wear, and tear, including obsolescence, of property. . .is that amount which should be set aside for the taxable year in accordance with a reasonably consistent plan (not necessarily at a uniform rate) whereby the aggregate of the amounts so set aside, plus the salvage value, will, at the end of the useful life of the property in the business, equal the cost . . . of the property." Thus:

Cost of surgical light, 1/1/46..$75
Estimated salvage value,
1/1/56 5
To be depreciated over 10 yrs..$70

Seven dollars should thus be the depreciation computed each year for ten years—with an appropriate deduction on each tax return.

Two Federal tax rulings bear closely on the establishment of a rate of depreciation. According to one of them, an error in judgment, stemming from inadequate consideration of known or *foreseeable* factors, usually cannot be compensated for in subsequent years. Hence, if you carelessly set the useful life of a surgical light at ten years—when with forethought you would have established it at only five—you cannot later increase the rate of depreciation to offset your poor estimate unless you can adduce evidence that an adjustment would be justified by circumstances.

On the other hand, the law recognizes that a sudden and *unforeseeable* loss of value in an article may be brought about by a radical improvement in design. Suppose the surgical light mentioned suddenly becomes outmoded in its fourth year of use. The $70 investment can then be depreciated over four years instead of ten, as originally estimated. This means writing off in the fourth year the difference between $70 and the sum of the depreciation taken in the first three years ($70 − $21 = $49).

This "straight-line" method of deducting a percentage of cost each year is the simplest, as well as the best for most physicians, although there are other officially recognized

but more complicated methods. The point is that your bookkeeping must show a *rate* of depreciation for each item, or group of items. If the useful life is estimated at ten years, the depreciation rate is 10 per cent; if fifteen years, 6 2/3 per cent; if twenty years, 5 per cent, etc.

In estimating depreciation, bear these factors in mind:

¶ Accelerated depreciation due to an increase in the rate of wear may be taken if its validity can be substantiated. Example: The depreciation rate on an automobile might be set at 25 per cent but increased to 33 1/3 per cent in a year with a heavy work load, such as 1945.

¶ The same depreciation rate can be applied to a group of items (*e.g.*, therapeutic lights) if the items are affected by the same wear and obsolescence factors.

¶ Incidental repairs on an item should be written off as an expense of the current year. However, a replacement which increases the life of the asset should be considered a capital investment and depreciated over a number of years.

¶ Depreciation, unlike other expenses, cannot be substantiated by a cash-disbursement entry. Your books must contain documentary evidence to support your claims should you be called upon to justify a deduction. The Bureau of Internal Revenue stipulates that such records be kept on "permanent books of account or auxiliary records."

When you have set rates for all items, you may, on your books, group those with the same rates (retaining—in card form—an individual record of the cost of each, its estimated life, salvage value, and rate of depreciation). Grouping, obviously, permits considerable saving of time when you come to estimate your income tax deduction.

The taxpayer is expected to set his own depreciation rates according to the factors which affect his investment in equipment. As a general guide, however, the Bureau of Internal Revenue offers a schedule of typical rates for a long list of common items. Included are the following:

Item to Be Depreciated	Depreciation Rate %
Books (of a permanent nature; not pamphlets)	5-15
Bookcases	5
Desks	5
Dwellings, brick (only professional section)	3
Dwellings, frame (only professional section)	5
Instruments	5-10
Lamps	10
Rugs, carpets	10
Typewriters	20

It is not necessary that all items in a group be the same age; they simply must have the same depreciation rate and be of the same general type.

Suppose that the balance in a group on January 1 was $1,000, and that $300 worth of equipment was purchased during the ensuing year. The depreciation computation then would be as follows:

$1,000 @ 10%, 12 mos.	$100
300 @ 10%, 6 mos.	15
	$115

Good accounting procedure assumes that all the purchased items were bought at midyear, even though they may actually have been acquired over the course of twelve months. —IRVING ELBAUM, C.P.A.

A Test for You

Probing one's faults is painful business. It takes courage. But it pays dividends.

So set your jaw and take a stab at answering the questions in the next column. There are eleven questions in all. Top score is indicated in parentheses after each; you're entitled to this if you can answer the question with an unqualified "yes." If you cannot, score yourself proportionately.

A total of 100 is perfect, entitling you to a cherry tree memorial; 80 is good; 70 passing; and anything below that a sign of need for early correction.

If your little helpmeet hasn't already filled in the scores on this test before you get it, let her have a crack at it also.

Reception Room

1. *Are there enough hooks for patients' hats and coats?* (8) ____

2. *Are reading lamps adequate in number and intensity?* (9) ____

3. *Is the temperature right?* (10) ____

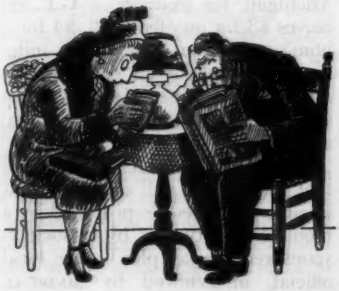
4. *Have you sufficient seating capacity?* (13) ____

5. *Are your magazines ample and up to date?* (6) ____

6. *Is the room pleasantly decorated?* (10) ____

7. *Are patients unable to hear nurse's phone conversations with other patients?* (6) ____

8. *Are diplomas taboo on the reception room walls?* (3) ____



9. *Is the room immaculate?* (18) ____

10. *Is it free from odors?* (10) ____

11. *Do you spare patients the sound of loud bells and buzzers* (7) ____

TOTAL ____

Hawley Would Expand Plans Providing Private Medical Care for Vets

V.A. prepared to approve any reasonable schedules of fees proposed

Thousands of private physicians may soon have an opportunity to participate in the care of veterans—on a fee-for-service basis. Through test plans developed under medical-society auspices, the Veterans Administration is already paying for private care in Michigan, Kansas, and New Jersey; and informed sources point out that the agency is anxious to see similar programs developed elsewhere. Says its Acting Surgeon General, Maj. Gen. Paul R. Hawley, speaking of one of the experimental plans, "I'd approve 2,000 others if they showed the promise this one does."

Payment to physicians is being made on the basis of fee schedules established by the cooperating societies and approved by the V.A. According to participating doctors, the fees are generally liberal; in Michigan, for example, a G.P. receives $3 for an office call, $4 for a home or hospital visit, plus a mileage allowance of 75 cents a mile after the first three miles. A specialist is paid $10 for a hospital consultation.

V.A. spokesmen have indicated that the agency will okay any reasonable fee schedule proposed by a medical society (or by a society-sponsored prepay plan). One local official, interviewed by MEDICAL ECONOMICS, put it this way: "We don't want the individual doctor to set the fee. We want to pay the prevailing fees for general practitioners and specialists in the area."

It is pointed out that the agency must make its working arrangements with medical organizations, rather than with individuals, since the V.A. cannot undertake to contract with the thousands of practitioners with whom it would otherwise have to have dealings. Hence, societies interested in a cooperative plan of this nature are being urged to set up committees empowered to negotiate with the V.A. and to handle administrative details after contract arrangements are completed.

A Washington (D.C.) newspaper editor, recommending further extension of the scheme by the V.A., said recently that 85 per cent of the country's veterans could probably be cared for locally under a nation-wide program similar to those now being tested. He based his belief on facts obtained in a series of first-hand investigations.

In Michigan, the plan is being operated on a state-wide basis through the Michigan Medical Service. The contract calls for office, home, and in-hospital care of (a) all male veterans with service-connected disabilities, and of (b) all

female veterans, without exclusions. In each case, the patient's eligibility must, of course, be authorized by the V.A. The agreed-upon fee schedule is identical with that of the MMS. All Michigan practitioners who wish to do so may participate, and patients are allowed free choice of all participating physicians. According to MMS officials, thousands of veterans are on the waiting list for examination by private practitioners—all presumably preferring such care to that available through the regular V.A. facilities.

Michigan Hospital Service (Blue Cross) is reported to be completing arrangements for a similar plan to cover veterans' hospitalization.

The Monmouth County (N.J.) plan, inaugurated in November, was rounding out a three-months' trial period when this issue went to press. Like the Michigan plan, it provides for private care of veterans by local physicians and hospitals, with the V.A. paying the bill.

Here is the plan, as approved by General Hawley:

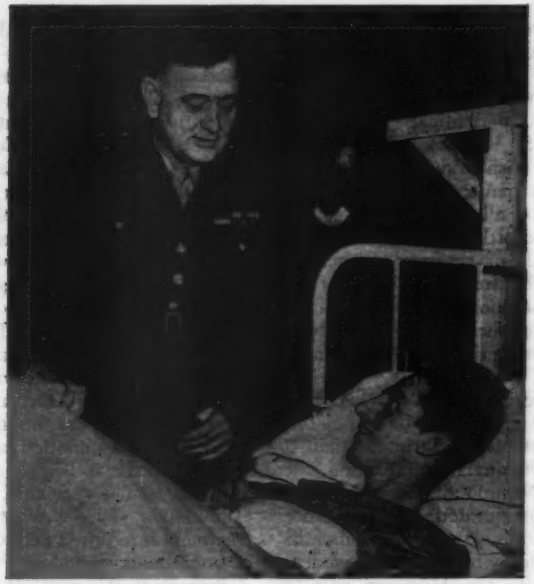
¶ All members of the county society, with their consent, have been designated part-time physicians of the Veterans Administration and authorized to bill it according to its fee schedule.

¶ The society has established screening clinics in suitable hospitals and staffed them with specialists, who work without remuneration on a rotating basis. The function of a clinic is (a) to determine by examination whether a veteran requires treatment; (b) to decide whether such treatment should be given by a general practitioner or specialist, in the hospital or in the home; (c) to refer cases which have received V.A. approval to the physician or hospital.

According to Dr. Granville L. Jones, president of the veterans committee of the Monmouth County Medical Society, evidence accumulating during the trial period indicates that the greater proportion of patients will be referred to general practitioners, fewer to specialists. The veteran is allowed freedom of choice to the fullest practicable extent.

A typical screening staff is composed of internist, psychiatrist, orthopedist, surgeon, dermatologist, and EENT man. When a veteran appears at the clinic, he is given a preliminary examination and then referred to the indicated specialist on the staff. The specialist, after his examination, decides what general treatment is required and what type of practitioner should give it.

Present at the clinic is a representative of the V.A. It is his function to decide whether a disorder is service-connected or to defer treatment pending further investigation. It is at this point that the Monmouth plan has found a major hitch: Although a veteran may have claimed a service-connected disability at the separation center, a delay in the transmission of his papers creates a problem for the V.A. representative who must pass upon the application for treatment. However, General Hawley recently instructed V.A. managers to presume that a disorder is service-connected pending adjudication of the veteran's claim. He added: "Obviously, [the rule] must be applied with reason. A veteran who breaks his leg certainly could not be presumed to have a service-connected disability. But in the great majority of cases



Maj. Gen. Paul R. Hawley in the days when he commanded the Army Medical Corps in Europe.

there should be little difficulty in making a proper decision."

The veteran encounters no red tape in gaining admittance to the clinic. He may come in of his own volition or through referral by his own physician, a veterans' organization, or a welfare group. In a single session recently, forty-four veterans applied at the clinic for private care.

Typical of their feeling about the plan was the comment one of them made to this reporter: "I was sick of G.I. care, so I went to my own doctor. He told me about this. I think it's swell. I get treated as if I'm a citizen—not Army property. I can come in here and the nurse says, 'Go right in and see the doctor.' And when I walk in, I don't have to salute. Boy!"

Not long ago General Hawley wrote the society: "I am watching your fine experiment with the greatest of interest. You have set an example—the Monmouth County plan is being discussed all over the country. Your initiative and spirit of public service has not only introduced something very real in the medical care of the veteran but has brought credit upon your society."

A similar plan is being drawn up by Monmouth County dentists, although it is unlikely that they will establish a screening clinic. Participation by nursing organizations has not yet been arranged.—G. W. WELLS

NPC Told That First Prepayment Plan to Reach Nation Will Win Support

Public not much concerned over sponsorship, opinion-poll director reveals at meeting

The first widely known and widely available plan of prepayment medical insurance to reach the American people—whether it be sponsored by the Government, insurance companies, or organized medicine—can count on public acceptance. This is the opinion of the Opinion Research Corporation, which has been conducting a nation-wide survey of public opinion for the National Physicians Committee.

A month ago, Claude Robinson, PH.D., president of the corporation, told a joint conference of the profession and industry in New York that "the present controversy over a Government-administered health insurance program is one which eventually will be settled by the people themselves. The doctors will of course bring their influence to bear, one way or another, but public demand will be the deciding factor."

Mr. Robinson reported that "The public is overwhelmingly optimistic that something can be done to ease the financial strain of medical expenses. And this optimism is growing: 8 per cent more people today than in 1943 say that something might be done."

Charts in the pages following indicate opinion on a number of questions asked by the ORC. Among other things, it will be seen that while only 34 per cent of the respondents expressed a *personal* preference for a Government plan, 55 per cent believed that it would be good for the nation as a whole, and an additional 8 per cent saw at least some possibility of good in it.

As to physicians: "The majority," Mr. Robinson told the meeting, "agree with the public that there is a need, but a startling minority—almost a third—flatly state that there is no need for anything to be done to make it easier for people to meet medical care expenses."

Among physicians

¶ 75 per cent thought that, from the standpoint of the public, a Federal plan would be bad; 23 per cent saw some possibility of good in it; 2 per cent had no opinion.

¶ 76 per cent thought that, from the standpoint of doctors themselves, a Federal plan would be bad; 21 per cent saw some possibility of good in it; 3 per cent had no opinion.

In this Mr. Robinson found an implicit warning: "Private plans will do well to publicize any success they have, for nearly a fifth (19 per cent) of the public now think that many doctors would not cooperate in private plans, and consider this the strongest argument against such plans."

Do you think there is a need for something to be done that will make it easier for people to meet the cost of doctor and hospital care?

YES 65%

NO 30%

NO OPINION 5%

Which do you personally prefer—the pay-in-advance plan or to pay just whenever you are sick?

PREFER TO PAY IN ADVANCE 64%

PREFER TO PAY JUST WHEN SICK 28%

NO OPINION 8%

If some pay-in-advance plan is worked out which you could join, would you rather have it come through the government or through a non-government source?

BEFORE plans are described

CHOOSE GOVERNMENT 41%

CHOOSE NON-GOVERNMENT 36%

13% MAKES NO DIFFERENCE

10% NO OPINION

AFTER

CHOOSE GOVERNMENT 45%

CHOOSE NON-GOVERNMENT 43%

4% MAKES NO DIFFERENCE

8% NO OPINION

Arguments in FAVOR of a GOVERNMENT plan

	SELECTED AS STRONGEST BY
It would assure more people medical care than ever had it before	38%
It would force people to protect themselves against future medical care expenses	25%
It would assure people in small communities and rural areas of getting care	23%
It would provide medical care at lower cost.	23%
National social insurance would be a good thing for this country	7%
It would provide better quality medical care	6%

Arguments AGAINST a GOVERNMENT plan

	SELECTED AS STRONGEST BY
A government plan would have too much politics and red tape	42%
People might not have free choice of doctors	23%
Doctors would take less personal interest in their patients	22%
A government plan would destroy doctors' ambition and incentives to get ahead and to keep up with advances in medicine	17%
A government plan would be socialistic	11%
The quality of medical care would not be as good under a government plan	9%

Arguments in FAVOR of PRIVATELY sponsored plans

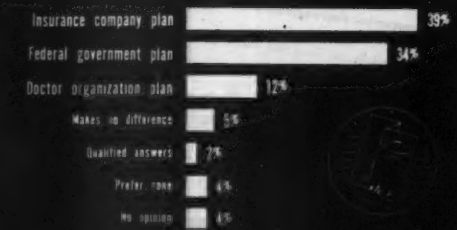
	SELECTED AS STRONGEST BY
People would not be compelled to pay into non-government plans but would be free to join if they wished.	24%
Doctors would do better work in the open competition of non-government plans	22%
Doctors and insurance companies would do more to make their own plans please the people	19%
Doctors and insurance companies would run such plans more efficiently than the government would	19%
Non-government plans help maintain free enterprise	17%
Such plans would not change the valuable personal relationship between doctors and their patients	12%

Continued on next page

Arguments AGAINST PRIVATELY sponsored plans

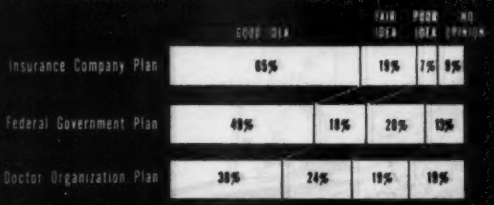
	SELECTED AS STRONGEST BY:
Many people would not join these plans unless forced to	30%
Many doctors would not cooperate in such plans	19%
The cost of medical care would be higher under a doctor or insurance company plan	19%
There would be too many variations and too many different plans	16%
Non-government plans probably would not cover all of the costs of medical care	15%
Many employers would not set up such plans	15%

Which of these three plans would you prefer for yourself?

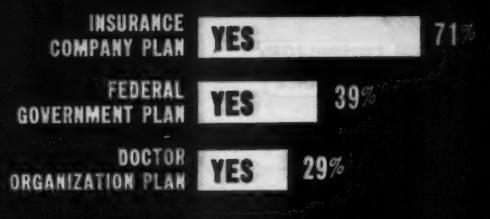


Do you think the Federal Government plan would be a good thing or a bad thing for the nation as a whole?

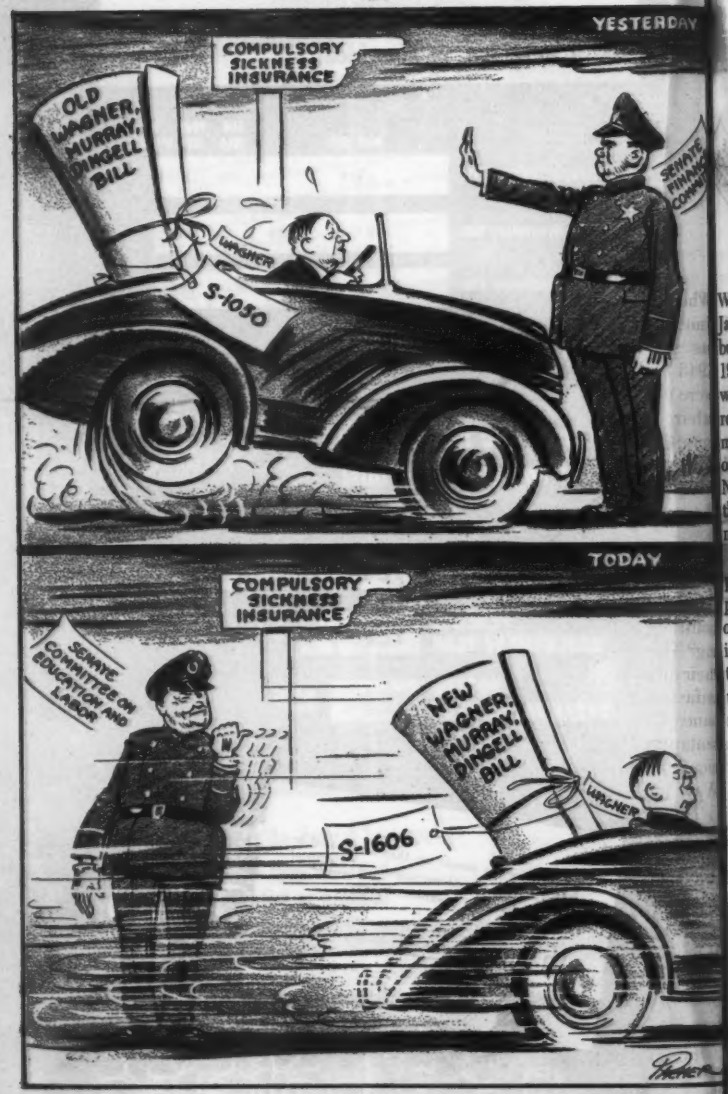
Would you say a plan like this is a good, fair, or poor idea?



Have you heard or read of any plans like this?



New Strategy, New Cop



S. 1606

An evaluation of the latest bill introduced in the Senate by Messrs. Wagner and Murray

When Senators Robert Wagner and James Murray introduced the omnibus social security bills S.1161 in 1943 and S.1050 in 1945, the bills were classified as tax proposals and referred to the Senate Finance Committee. The committee promptly sat on them. No hearings were called. No action was taken. For two years the sponsors of the legislation got nowhere.

Then they had an idea: Since tax proposals were not notable for their popularity, why not write a new bill, omitting all reference to fund-raising? This would make it possible for their measure to by-pass entirely the unfavorably disposed Senate Finance Committee (and for Representative John Dingell's companion measure in the House to by-pass the Ways and Means Committee).

The maneuver was tried, and it worked. The new Senate bill S.1606 was referred to the Committee on Education and Labor, of which Senator Murray himself is chairman; while the identical House bill H.R. 4730 was referred to the Interstate Commerce Committee, headed by Representative C. F. Lea of California.

If these measures should be enacted, separate legislation to finance them would have to be passed also. But by that time, the sponsors hope, enough public demand would have been created to carry the program over the top.

The Wagner-Murray-Dingell bill is of course one of the principal means of implementing the health program proposed by President Truman in his November 19 message to Congress. In that message, it will be recalled, the Chief Executive took turns renouncing socialized medicine in one breath and eulogizing it in the next. This tendency to blow alternately hot and cold on the idea is being explained on grounds that Mr. Truman is not completely sold on compulsory sickness insurance but feels compelled to support it because, during his term in the Senate, he promised his New Deal colleague, Mr. Wagner, that he would.

The President's uncertain position is also being explained by the allegation that his health message was dictated in its original form by the Social Security Board's arch socialist, Isidore S. Falk, and that after Mr. Truman got through trying to modify it, the speech, as could be expected, was something less than uniform in its ideology.

Whatever may be the Chief Executive's real attitude, if any, to-

Handitip

Check!

You know the type: "I intended to give you a check, this visit, but I've left my checkbook at home." With an air of being helpful, reach into a desk drawer for a blank check, a pad of which you've bought from a stationer. And for the patient at home who has left his checkbook "at the office" have a pad of blank checks in your bag.

---

ward S. 1606, there is no doubt about that of Senators Wagner and Murray. The latter, as chairman of the Senate committee considering the bill, promises to follow through promptly with the hearings and with subsequent action on the floor of the Senate.

High spots of S.1606 are as follows:

It would cover practically every man, woman and child in the United States, regardless of income. Services provided would include general medical, dental, hospital, nursing, specialist, laboratory, etc. Any licensed physician could participate. The names of those who did would appear on lists published by the Surgeon General of the Public Health Service. From those lists, persons insured would select their doctors. Participating physicians would be paid on either a fee-for-service, capitation, or salary basis, or according to a combination thereof. Payments might in time be on a nationally uniform basis. The Surgeon General would be authorized to make grants-in-aid for medical education and research.

The benefits to be provided by the bill are classified broadly under two headings:

1. Community-wide health services;

2. Prepaid personal health services—*i.e.*, compulsory sickness insurance.

The community-wide health services would include (a) expanded public health services, (b) maternal and child health and crippled children's services, and (c) medical care for the needy. The administrative agencies for these three services would be, respectively, the Public Health Service, the Children's Bureau, and the Social Security Board.

States would receive Federal grants-in-aid for such community-wide services, ranging from 50 to 75 per cent of what each state spent for the three programs. Maximum Federal aid would go to the states with the lowest per capita incomes.

Although the compulsory sickness insurance benefits provided by the bill would apply primarily to workers and their dependents, such benefits could also be obtained for other persons, such as the needy, those entitled to workmen's compensation, veterans, state and local governmental employes, crippled children, the self-employed, and others on whose behalf a public agency had made equitable payments into the Federal Treasury.

Any physician, dentist, or nurse legally qualified by a state would be allowed to furnish services under the act. The Surgeon General would designate those entitled to rate and be paid as specialists or consultants. The patient would be permitted to select a practitioner from among those in his local area who had contracted with the Federal Government to furnish services in accord-

ance with regulations to be issued by the Surgeon General. Services of specialists or of consultants would not be available ordinarily except on the advice of the general practitioner.

Whether the general practitioners in an area would be paid on a fee-for-service, capitation, salary, or combination basis would be decided by vote of the practitioners themselves. But the Surgeon General, in paying practitioners who did not elect the majority method, could also make payments by any of the other methods listed. Specialists and consultants would be paid on a per session, fee-for-service, per capita, salary, or other basis, or combination thereof, according to agreements with the Surgeon General.

In any area where payment of general practitioners was on a capitation basis, the Surgeon General would be required to make per capita payments to all cooperating practioners for all persons who were entitled to medical benefits but who, after due notice, had failed to select a practitioner from among the PHS-listed doctors in that area. That is, persons eligible for benefits would be paid for *whether or not* they used the services of the doctors on the Government panel.

Every individual entitled to medical, hospitalization, and related benefits under the act "may be required by the physician, dentist, or nurse furnishing such benefit to pay a fee with respect to the first service or with respect to each service in a period of sickness or course of treatment." Other limitations are authorized also as punitive measures to prevent or reduce abuses.

There would be created on the books of the U.S. Treasury an account to be known as the "Personal Health Services Account." Congress would be authorized to appropriate to this account such sums as might be necessary to finance the benefits, payments, and reimbursements provided in this title of the bill. The Federal appropriation would be made up of several parts, including: an amount equivalent to 3 per cent of the wages (up to $3,600) of employed persons and of the earnings (up to $3,600) of the self-employed; sums from general revenues to cover expenditures for dental and nursing services; sums from general revenues to pay for the medical care of retired and survivor beneficiaries of the social insurance system who became insured before the bill went into effect; and reimbursements made on behalf of non-insured persons (the needy, workmen's compensation cases, etc.).

While Senator Wagner in introducing the new bill stated that the method of financing the national health program would be left to Congress, the benefit structure of the "personal health services" program is practically identical with that in S.1050.

In proposing to expand the nation's presently accepted community-wide health services, Mr. Wagner and his associates are on safe ground. Their bill is, in fact, sweetened with many such provisions, to which not even the most hidebound reactionary could object. Some of the drawbacks, critics say, are less apparent. For example:

States wishing to have Federal medical care provided for their needy, for their workmen's compensation cases, for state and local governmental employes, and for others not specifically covered by S.1606,

could secure it by making appropriate payments to the Federal Treasury. Thus the way would be opened for the Social Security Board to tap the fiscal resources of states in order to swell the size of the Federal social insurance fund. And as the money paid in went through the Federal "wringer," a "cut" would undoubtedly be taken to pay the salaries of Federal administrators. Another effect would be to bring under Federal control all physicians serving the non-insured groups mentioned.

In expanding community health services as described, the Wagnerians propose to deposit the sick poor of the country on the doorstep of the Social Security Board, an agency which still has no health or medical staff and no administrative experience in local health or medical activities. Thus the Social Security Board would join the Public Health Service, the Children's Bureau, the Veteran's Bureau, and the Department of Agriculture as one more Federal agency authorized to administer medical care programs.

Many believe that the health fund required to make S.1606 operative should be held in a completely separate account and managed by a board of trustees independent of those managing the social security (*i.e.*, income-maintenance) funds. But since S.1606 does not guarantee the integrity or separateness of the health fund, none may be intended. It is possible, therefore, that if both S.1606 and a compulsory insurance tax measure were passed, the health fund would be lost in the larger insurance fund. Physicians, dentists, nurses, and hospitals would then have no assurance that funds for their services would be protected. In Great Britain the capitation fees of physicians have repeatedly been reduced when the Government has been faced with other pressing demands for money.

Senator Wagner makes the statement that S.1606 would make "medical services more generally available than they are today, while retaining free choice of doctor for the patient and freedom on the doctor's part to work under the system or to remain out of it as he prefers." At the start, before the compulsory scheme became fully operative, it is possible that physicians might elect to accept or decline insurance practice. But as the scheme spread to include virtually the entire population, all physicians would be compelled to participate if they wished to remain in medicine.

—CARLTON RUSSELL

Family Likeness

A woman patient complained of backache and pressure symptoms. Her husband showed us X-rays of a malignant lesion. This was contrary to our examination and her history, but the patient was hospitalized and new X-rays were made. These showed no lesion at all. Close questioning finally brought enlightenment to us—and acute embarrassment to the husband: The X-rays were those of his first wife.

—FRANCES COMPTON

FIRST VISIT

Your relationship with the patient is determined at the moment of your initial meeting

Most patients are by nature suspicious. And so would most physicians be if *they* were patients.

In too many cases, the doctor is not a first resort—as he should be—but a last; only if a state of emergency makes itself felt will the patient seek medical aid. When he finally reaches your office, he has gone through many stages of preparation: He has made an appointment; he has taken an extra bath; he has snatched time off from his job; and he has worried over the financial consequences of the consultation.

Treatment begins in the reception room, which may be desolate or highly reassuring. Some of us use our reception rooms as attics in which to store the rubbish of ages, with hard chairs and gloomy lights and a carbolic air. Others, by contrast, have comfortable, pleasant quarters where the patient can find cheer and ease.

▶ The author, Dr. Martin Gumpert, is a practicing internist. Articles by him have appeared in The Reader's Digest and in other national periodicals. He has written a number of books and is Time magazine's medical editorial consultant.

The doctor's as yet hidden personality is gauged by every piece of furniture, by every picture and book. It is reflected in the attitude of his nurse or his secretary and, most of all, in the appearance of the other fellow-sufferers: whether, while waiting, they are relaxed or tense; whether, when called, they seem frightened or expectant.

There are apparently two theories among physicians as to whether patients should wait indefinitely or whether they are entitled to strict punctuality. In my opinion, abuse of the patient's time is one of the most widespread and least excusable medical sins. No longer are people awed by the apparent busyness of the doctor who makes them wait. He becomes, instead, a symbol of inefficiency and rudeness. For many patients have learned that the physician with the largest practice is frequently the most punctual. If an undue delay occurs, therefore, let a reason be given the patient and suitable apologies made.

Only rarely will the confidence the physician inspires during the first few minutes of the first visit be increased later. It is the voice, the appearance, the manner, the evident knowledge, and the honesty of the doctor that win or scare away new patients. The object is thus to create an impression of health, neatness,

intelligence, and understanding. Yet even these good qualities must be modified by a certain neutralness: You must not be too jovial, too elegant, too erudite, or too removed from everyday life.

Let the consulting room be free from noise and outside interference. Nothing is more exhausting to a patient than inability to finish a sentence because of constant telephone interruptions. The room should be completely cut off from treatment rooms and laboratories. Only the most essential equipment of the profession should be visible (framed certificates, Rembrandt's "Anatomy Lesson," and the lithograph of the doctor and dying child are better omitted). If the patient smokes, he will be grateful for a cigarette; and it will put him at ease because most patients seem to be convinced that a doctor hates others' smoking.

It is not necessary to obtain all the patient's personal data, including telephone number and name of employer, before starting the discussion. Some of this can be collected at the end. It is certainly better to avoid all the more inquisitive procedures at the start and concentrate without delay on the patient's actual trouble.

The patient at a first consultation should feel that plenty of time is available to him. He must be assured that he is welcome to express everything he has on his mind even if he lacks the gift of explaining himself quickly and even if he seems to talk about everything but his complaint. The physician may have formed a clear and correct judgment of the case in the first moment, but the talkativeness of the anxious patient is a therapeutic measure in itself. What's more, since the perfect listener usually creates the illusion of complete understanding, the physician thus finally receives the essential information he wants about the patient's emotional and mental situation, about his occupation, family habits, and fear—without which rational treatment cannot be advised and cannot be successful.

If such confessional exercise is denied, the patient will feel he has not been able to explain the really important part of his ailment and that his doctor, therefore, is not in a position to cure him. This feeling is often justified. A patient removed from his family is in many cases like a limb without a body. His difficulties appear in a very different light after we have learned from him about his relatives, friends, and associations. It is also a fact that extra time spent on first consultations will be rewarded by the patient's personal liking and cooperation. Every experienced physician since Hippocrates has practiced what is now reborn under the high-flown title of psychosomatic medicine.

There is certainly nothing more disappointing and insulting to a patient than to dismiss his complaint as unfounded or negligible. Considering all the difficulty he has experienced before appealing to our judgment, it is worse than calling him a liar. A person who feels ill is ill—or soon *will be*. And he has a right to expect help from his physician.

The practitioner does not want to frighten the patient by emphasizing the seriousness of a major ailment. Nor, on the other hand, should he minimize a minor ill. Most ailments are "minor" or start as such.

The doctor who removes a corn from a patient's foot and so in

proves motility not only gives the patient necessary, even vital treatment, but earns more gratitude than his colleague who discovers auricular fibrillation or an increase in blood sugar. Remember that what seems to *us* important and interesting is to the *patient* nothing but a name unless translated into an actual ache or pain.

Truthfulness to the patient is the basis of an honest medical practice. But the truth can be told in different ways. If a new patient comes into our care, it is the beginning of a long educational process in which the doctor is the responsible teacher. Even the best-educated people often have only the most childish conception of what is going on inside their bodies. In order to become a reliable partner to their physician in the management of their bodies, they must learn by asking questions, and we must be glad to answer these questions in an understandable way.

A suggestion which is offered here and which may meet with objection in some quarters is to entrust the intelligent patient with information from the records and findings made during treatment. If he *is* intelligent, he will be grateful for the confidence. Even if the findings are hieroglyphs to him, he ought to be trained from the beginning to keep his health record just as he keeps his tax record. Many physicians refuse to allow the patient to have this material, for which he has paid, so an embarrassing situation arises when he wishes to change doctors. Usually, everything has to be started all over again. In my experience the patient feels more independent yet more attached and reliant if he becomes, so to speak, the physician's first assistant.

When a new patient enters the office we can often observe his worry over what this adventure may cost him and his obvious relief when we frankly discuss the matter. We may find it convenient to name a minimum and a maximum fee for medical service and leave it to the patient's discretion to classify himself within that range. Even people in very poor circumstances should pay something, unless the fee is covered by a charity, welfare, or insurance agency, or unless the case is an emergency.

The patient feels better if he is not asking for charity. And it is the general experience that a person who is treated without fee will never be cured anyway until he goes to another physician whom he has to pay.

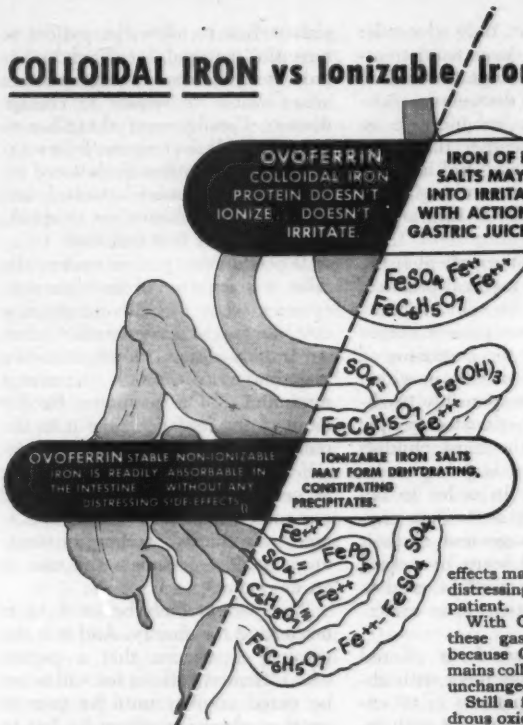
Every new patient is—or should be—a challenge and an adventure. Most people have developed an instinct for recognizing a good physician when they meet one; they will come as strangers and leave as friends. —MARTIN GUMPERT, M.D.

Syphilitic Justice

"How do you decide on your syphilitic applicants for insurance?" I asked the medical director of a large carrier. "We insure those who lie to us; we reject those who tell the truth," he replied.

—ANONYMOUS

COLLOIDAL IRON vs Ionizable Iron



No disagreeable taste. Does not stain teeth.

IN TREATING HYPOCHROMIC ANEMIAS, Ovoferrin, colloidal iron-protein, is an easily assimilable hematinic that acts without irritating the stomach or intestine, without dehydrating the bowel, without staining or dissolving tooth enamel.

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With Ovoferrin none of these gastric upsets occur because Ovoferrin iron remains colloidal,—practically unchanged by gastric juices.

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Ovoferrin's palatability makes it acceptable to the patient with hypochromic anemia, the convalescent, the chlorotic child; in pregnancy and lactation; and in debility states.

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OVOFERRIN *COLLOIDAL ASSIMILABLE IRON*

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Proloid is *biologically* standardized as to actual metabolic potency . . . obviating the usual necessity for sole reliance on iodine content to determine potency.

Proloid is recommended wherever U. S. P. thyroid is indicated—in the same dosages. The Maltine Company, New York. Established 1875.

PROLOID for thyroid therapy

A National Health Congress

Why it is needed, what it could accomplish, and how it might be organized

Few physicians, if any, would vote for the Wagner-Murray-Dingell bill were they sitting in the Senate or the House when it came up for consideration. On the other hand, everyone favors the purported objective of the bill, which is adequate health care for *all* the people of this nation through a comprehensive health plan.

The public knows the value of health; the public wants health; and the public is determined to get it—one way or another. If the private health forces do not give the people a health plan, they will accept one from the Government.

Fortunately, the green light is still on for voluntary health care. And the public will choose such care if you make it possible for them to have it. All the surveys we have studied, including the two we ourselves made in California and Michigan, prove conclusively that when the public is given a *choice* of alternate plans the majority will invariably select a voluntary plan to one which is state or federally controlled.

There has been a great deal of negative and belligerent publicity against the Wagner-Murray-Dingell bill. I would like to say to you that such publicity will in the end avail you nothing. Too many of our otherwise intelligent doctors have been running around trying to put out a five-alarm fire with squirts from their own little hypo needles.

You physicians are usually realistic people. In your profession you have to be. Doesn't it seem sensible, then, to bring to the diagnosis of your own problem the same factual, down-to-earth thinking that you apply to the condition of a patient? If you do this, you must agree that you have no cure for your problem until you offer the American public on a voluntary basis a health plan as comprehensive and as attractive as that which proposed legislation would ostensibly bring to the public on a compulsory basis.

And let me remind you, in your realistic approach to curing your patient, you don't say, "I've thor-

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▸ John F. Hunt, the author, is vice president of Foote, Cone & Belding, advertising agency, which has been conducting public opinion surveys on the cost and distribution of medical care. This article approximates an address Mr. Hunt made before the first annual Conference of Presidents and other Officers of State Medical Societies on Dec. 2 in Chicago. Before reading it, turn to the editors' note on page 40.

ERYTHROL TETRANITRATE MERCK in Angina Pectoris

It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For this purpose, the rapidly acting nitrous and nitric acid esters, amyl nitrite and nitroglycerin, are considered most useful.

For prophylactic purposes—to control anticipated paroxysms—the *delayed but prolonged action* of erythrol tetranitrate is more effective. Erythrol tetranitrate, because of its slower *and more prolonged action*, is also considered preferable for the purpose of preventing nocturnal attacks.

The vasodilatation produced by Erythrol Tetranitrate Merck begins 15 to 20 minutes after administration, and lasts from 3 to 4 hours.

The properly timed administration of a vasodilator having a sustained effect may prevent the following episodes of angina pectoris:

- **The man who finds it necessary to stop and rest when he walks to the train in the morning.**
- **The man who suffers "indigestion" and "gas" on exertion, or after a heavy meal.**
- **The man who has pain in his chest and arms, and weakness upon any anxiety, anger, or nervous strain.**

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

are to put together a completely democratic body for the purpose described it must of necessity be a large one.

Numbers, of course, do not inevitably mean confusion and turmoil. This fairly large body of men would work by committees—just as our national Congress works. And that body succeeds in getting things done. If the voluntary health people adopt this proposal a way may be found later to streamline the National Health Congress into a more compact group. This would be possible, for instance, if all states (instead of only several, as now) were organized under their own state health councils.

To my statement that our national Congress gets things done, you may reply, "Yes, but they have all year to do it." This is true. It is also true that a large voluntary organization like the National Health Congress cannot be in session for long periods of time. A week or ten days each year may be all that members can afford. This has been recognized. The suggested structure of the health congress makes provision for this in the form of a permanent, salaried administrative staff.

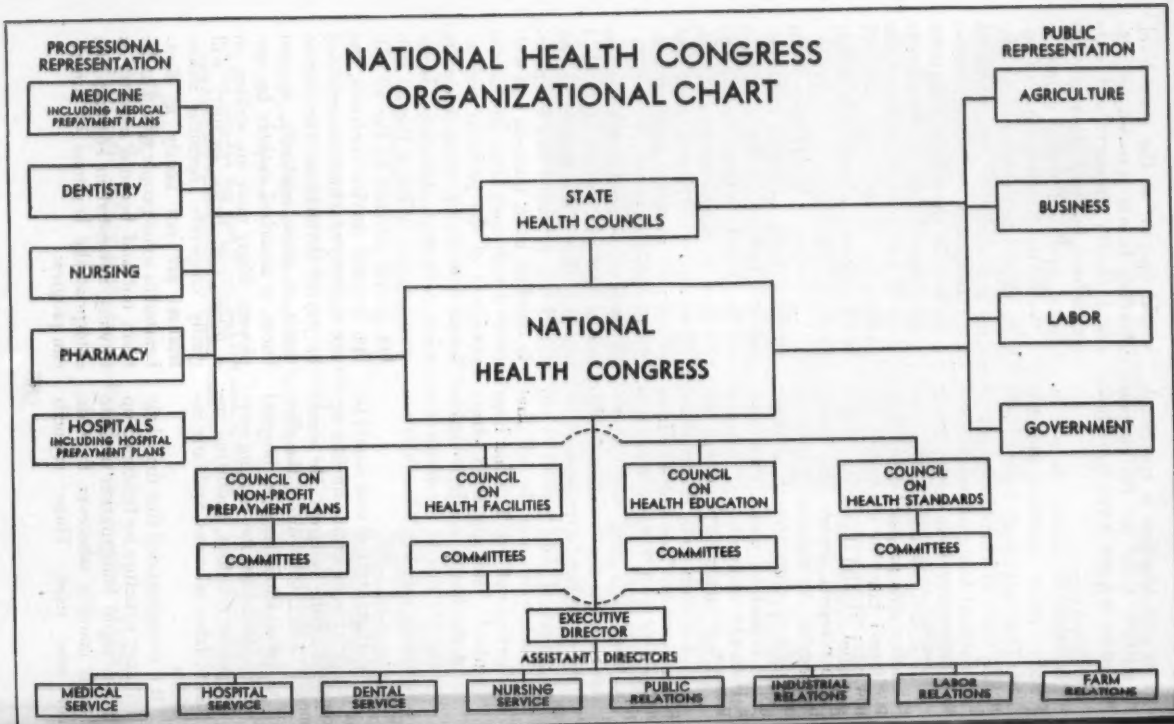
The administrative staff would be headed by an executive director appointed by the congress. He would select assistants to direct the divisions of medical service, hospital service, dental service, nursing service, public relations, industrial relations, labor relations, and farm relations.

It is recommended that the whole voluntary structure be tightened up by the rapid inauguration of state health councils wherever they do not now exist. These councils would operate at the state level, affording liaison between the National Health Congress and state agricultural, business, labor, governmental, and professional groups.

Would the National Health Congress appeal to the consumer? The answer is definitely yes, provided the consumer is invited to become a partner in the whole enterprise and is assured that the congress is honestly set up to whip the health problem for *all the people* and will not become a tool to further selfish medical interests.

A number of letters have been received from industrial and agricultural leaders in response to a mailing which outlined briefly the National Health Congress proposal. These replies evidence a great deal of interest; most are hopefully enthusiastic.

Speaking as a self-appointed representative of business, I think I may say that if this congress is put together as proposed on a completely unselfish basis, business will welcome it with open arms. Business is conscious of the problem and interested in doing what it can to solve it through voluntary, democratic means. Witness the 20 million people covered by the 10 million hospital service contracts, the vast majority of which are activated by payroll deductions. The cost of many of these contracts, as you know, is absorbed entirely by employers. Many more are written on a 50-50 cost basis. Industry will gladly cooperate, because industrialists are not nearly as flinthearted as some people would make them out and because industry is fervidly interested in keeping free enterprise the keystone of American progress.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COUNCIL ON HEALTH STANDARDS
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COMMITTEES
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ASSISTANT DIRECTORS
MEDICAL SERVICE
HOSPITAL SERVICE
DENTAL SERVICE
NURSING SERVICE
PUBLIC RELATIONS
INDUSTRIAL RELATIONS
LABOR RELATIONS
FARM RELATIONS

oughly diagnosed this case; I know where the trouble is; and some day next month, next year, or the year after—when I get around to it—I'm going to give him some medicine." No, you don't do that with other people's ills. As soon as you have located the seat of the trouble *you go into action.*

You must follow the same strategy if you are to save free enterprise in health care. You must start now. The National Health Congress is offered as a plan for action. We believe it affords a means of accomplishing under voluntary control as much as, if not more than, is promised the public under the Wagner-Murray-Dingell bill.

What is the National Health Congress? Briefly, it is a proposal for merging or coordinating the abilities and facilities of all the voluntary health forces. Its purpose is to make complete health care available to everyone through voluntary means and at a price he can afford to pay. Its further purpose is to raise even higher the standard of health care now existent in this country.

Why is the National Health Congress now proposed? Because it is not possible for any one segment of the voluntary health forces to accomplish alone what the Government proposes to foist upon the people by compulsion. It is true that individual ventures such as the Blue Cross and medical society plans can go quite a way toward meeting the health needs of our people. But they cannot encompass *all* the activities that must necessarily be included in a completely comprehensive health plan for all the American people. The only possible answer is coordination of the health professions' total abilities and facilities.

You and the public can effect a voluntary health plan if you will agree to cooperate. The blueprint is before you. You can either build your own house or have the Government build it for you—and run it for you. There is no alternative.

Is the idea of a National Health Congress perfect? No, I am sure it is not; nothing as big as this could possibly achieve perfection in its first draft. But it is a basically sound concept of how you must organize to do what you have to do. The Constitution, when drafted, was as good as the founding fathers could make it. Since then its reputation for perfection has grown apace. Yet I needn't tell you that even that document has seen some twenty-two amendments since it was first adopted.

Is the concept of a National Congress too big? No. When the problem is big the solution must be big. If you admit that a merger of all our voluntary health forces is impossible, you admit the defeat of those forces in their effort to provide voluntary, national health insurance. Under the circumstances, it would be more sensible to forget your devotion to a voluntary service and let the Government do the job.

Would the National Health Congress be too unwieldy? We believe not. The congress, as proposed, calls for elected or appointed representatives of medicine, dentistry, nursing, pharmacy, hospitals, industry, labor, and agriculture from each of the forty-eight states, plus one seat each for the U.S. Senate, House of Representatives, and Public Health Service. This makes 387 members, which we agree is a fairly sizable organization. But if you

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All Hygeia national ads say:
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HYGEIA NURSING BOTTLES
NIPPLES WITH CAPS

Sold complete as illustrated, or parts separately

If the National Health Congress is built right, industry's interest will be matched by that of our farm leaders. There is plenty of evidence on which to base this assertion.

And how about labor? As you know, labor has declared itself in favor of the Wagner-Murray-Dingell bill. But it has done so because it has despaired of ever getting a national health plan from the voluntary forces. If this congress is established as proposed, with labor properly positioned in it, the voice of labor will be singing in your chorus instead of doing its strident solo in the other choir.

Would the National Health Congress interfere with existing professional organizations? It would not. In fact it would be actually beneficial. By providing a truly national stage for medicine, by utilizing all the abilities of the present organizations, and by enabling them to be further extended, it would make any sound, existent organization more useful to its members as well as to society as a whole.

Who should bring the National Health Congress out of the idea stage and into action? Medicine should. While this proposal will not emerge as an organization *by* and *for* the medical profession, it is thoroughly logical that the medical profession should give it its start. If you are convinced that the voluntary forces can put together a plan which will completely take care of the health needs of all the people—if you are convinced that this National Health Congress proposal is basically sound and workable—then we believe *you* should reach out for this idea and put it into action.

And I mean action *now*; for the time is short unless you are willing to sit supinely by and see the health of the nation and your own profession sold short.

The National Health Congress needs your support. [It has already received the endorsement of the American Medical Association—Ed]. It needs incorporation to make it a "going business." I am confident that you will have an immediate consumer following if you just begin to show by action—not by words—that you appreciate the necessity of bringing health protection to all the people, and that the voluntary forces are big enough to accept the challenge which is being politely but firmly thrown into their faces by the National Government.

—JOHN F. HUNT

Fission

Shortly after our country laid its highly exposive eggs on Hiroshima, a middle-aged patient consulted me. His story suggested a chronic prostatitis. After the usual questions relative to urinary difficulty, I asked him about the presence or absence of low backache, and its radiation. With that he stood up, and demonstrated its location. Sweeping his hands around his sides and down the inguinal canals, he said: "It goes clear down to my atomic bombs!"

—JUDSON B. GILBERT, M.D.

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ANTIPHLOGISTINE, due to its formula, maintains moist heat for many hours.

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POSITIONS FOR WAR-VETERAN PHYSICIANS

Any physician returning to civil life from the armed services or from a war agency may insert *free* in the domestic edition of MEDICAL ECONOMICS (circulation: more than 100,000) a position-wanted classified ad (maximum: 24 words). The following data (which will be kept confidential) must accompany the copy for each ad: name; address; rank or position; date. Copy must reach MEDICAL ECONOMICS by the 5th of the month preceding publication. Address: Veterans' Service Editor, Medical Economics, Inc., Rutherford, N.J.

ANETHETIST available; 5 years' experience inhalations (including cyclopropane and endoctracheal), intravenous, and regionals (spinal, caudal, and block). Part time preferred. (Now in N.Y.) Box 1520.

ASSISTANTSHIP leading to permanent association sought; alternative: full-time industrial position. (Now in N.Y.) Box 1532.

ASSOCIATION with general practitioner wanted, or will take over office. Prefer New York. Interested in pediatrics. (Now in N.Y.) Box 1530.

ASSOCIATION with G.P. desired by veteran with two years' internship, seven months' graduate training, one year of general practice; West Coast or Northwest. (Now in Wash.) Box 1525.

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DERMATOLOGIST, certified, seeks new location. Prefers home-office in 100,000 city or position with group. Cooler state desired. (Now in New York.) Box 1511.

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INDUSTRIAL position wanted; pre-employment exams, minor surgery. Or locum tenens, two to six months, general practice. (Now in Col.) Box 1526.

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OPHTHALMOLOGIST would like to associate with a new or established group in New York, New Jersey. (Now in N.Y.) Box 1537.

OPHTHALMOLOGIST, young, energetic, certified by American board; California license. Desire association with progressive group or with EENT man. Los Angeles area preferred. (Now in Mich.) Box 1528.

OPHTHALMOLOGY. Veteran now taking approved graduate course desires residency, one or two years, beginning about July. (Now in N.J.) Box 1538.

RADIOLOGIST, diplomate American board, desires full-time employment or other suitable association in New York area. (Now in New York.) Box 1508.

RADIOLOGIST, diplomate, desires part-time employment or other suitable association, New York metropolitan area. (Now in N.Y.) Box 1535.

RADIOLOGIST, 33, qualified in diagnosis and therapy, seeks position with group or hospital, or will purchase private practice. (Now in N.Y.) Box 1536.

SMALL-TOWN PRACTICE, unopposed, desired by physician, 31, graduate of approved school. Alternative: appointment in psychiatric hospital. (Now in Penna.) Box 1516.

SURGICAL or urological assistantship desired by physician, 36; eight years active civilian and military hospital experience. Licensed by California, Minnesota. (Now in Minn.) Box 1533.

TROPICAL DISEASE experience; desire post in Africa, South America. Know care and direction of natives; interested in surgery. (Now in N.Y.) Box 1527.

WRITER. Physician desires work writing booklets, pamphlets, or ethical advertising on drugs, vitamins, foods, or other medical subjects. Experienced. (Now in New York.) Box 1504.

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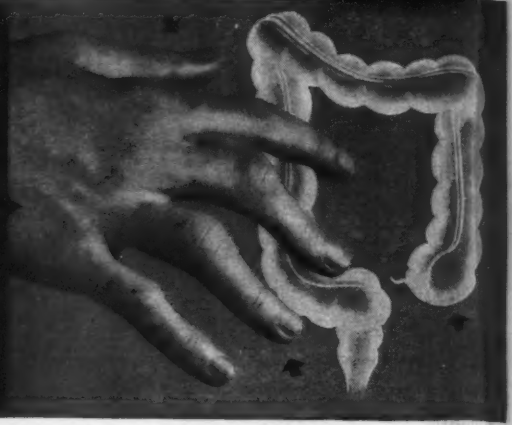
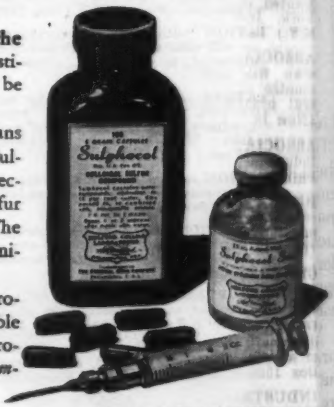
NORMALIZE the METABOLIC PROCESSES in the Treatment of Arthritis



A WIDE divergence of opinion exists as to the etiology of arthritis. However, several investigators agree that metabolic changes may be one of the important factors.

To correct metabolic error, many physicians have employed colloidal sulfur therapy. Sulphocol capsules and Sulphocol Sol (for injection) provide a large supply of utilizable sulfur in a concentrated and economical form. The colloidal sulfur is dispersed in a readily assimilable protective colloid.

Sulphocol is safe and non-toxic. Gastro-intestinal disturbances or other undesirable effects have not been reported. Write for professional literature. *The National Drug Company, Philadelphia 44, Penna.*



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Sigerist Sees Kaiser Plan, Soviet System Parts of Same Pattern

Socialized-medicine proponent lauds "efficiency" of Russian program

When a month ago, Dr. Henry E. Sigerist described Russian medicine—and what he believed to be its implications—before a forum sponsored by the New York Herald Tribune, that highly conservative newspaper termed him "a foremost advocate of socialized medicine and national health legislation." This will not come as news to American physicians, but since Dr. Sigerist is still beating the drum publicly for state medicine, the editors of MEDICAL ECONOMICS believe that its readers should be kept abreast of his activities. Here is what he told the lay audience at the Herald Tribune forum.

Last year Henry J. Kaiser said that "To live abundantly and take part in the productive economy, our people must have health. This is not only a matter of medical science, but of facilities. Health service can be rendered on a self-sustaining insurance basis, at a price well within the reach of all."

We admire Mr. Kaiser not only for the ships he built during the war but also for the medical services he organized in his shipyards for his workers. He demonstrated that first-rate, modern, scientific medical care can be provided at a price that people can afford.

During the last fifteen years I have been studying the organization of health services in a great many countries, on four continents, and I have served various governments in preparing plans for post-war health organization. It always struck me that wherever you attack these problems and try to find a solution that would bring good medical care to the people, you devise a system that is in many ways similar to that of Mr. Kaiser—that is, a system under which medical care is given the people through medical centers by organized groups of physicians, whereby the services may be financed either through taxation, insurance, or a combination of both.

It is not by accident that every country sooner or later finds that this is the kind of health service that the people should have. It is the result of the present technology of medicine. With the scientific knowledge

U.S. mouthpiece of Soviet medicine is Dr. Henry E. Sigerist, director of the Institute of the History of Medicine at Johns Hopkins. Long an advocate of a system of state medicine, Swiss-born Dr. Sigerist established "the first practical course" in it in this country.

and technical means that medicine possesses today, we can no longer practice medicine from a medicine bag, as the old country doctor used to do. We need in many cases the advice of specialists and the findings of the laboratory, and there can be no doubt that group medicine practiced by an organized group of physicians working under one roof is infinitely more efficient, and cheaper in the long run, than individual practice.

I was interested to see that the health services that are practiced on a small scale in the Kaiser shipyards are of the same type as those that the Soviet Union has been practicing on a nation-wide scale for over twenty-five years. Mr. Kaiser is justly proud of the seven medical centers that he is operating, but in 1941 the Russians had built and were operating 26,973 such centers. I think we should not be afraid to look at the USSR and to study its social service very carefully. I, for one, have spent three summers in that country and have studied the organization of its health services in great detail. From every such trip I came home with the conviction that the Russians were building up the kind of health system that was able to make the greatest use of the present advanced technology of medicine.

The idea is extremely simple. The Russians have a special word to designate what we mean by medical care, medical services, public health, etc. It is "zdravookhranenie," which literally means the protection of health. Indeed, the goal there as here and everywhere is to promote the people's health, to maintain and protect it, and to restore it when prevention has broken down. To that end all health services are free of charge in the USSR and therefore available to all the people. Health is recognized as something that is essential for the welfare and normal functioning of a community, like education, and that therefore it should be made easily available to the people—like education. As a matter of fact, the Soviet citizen has a constitutional "right to material security in old age and also in case of sickness or loss of capacity to work." "This right," says Article 120

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- **— Reduces variations in blood levels**
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Here's the penicillin preparation that makes this drug really practical! *No heating or other fancy "fixings."*

Penicillin in Sesame Oil and Beeswax Cutter, offers all the benefits of delayed absorption—including that of maintaining more constant blood levels, so difficult with the 3-hour material.

But more—it requires no strong-arm tactics! Even directly out of the refrigerator, you need only hold it under hot water for a moment, and it flows freely. Easily drawn into syringe and injected in an accurately measured dose.

Ask your pharmacist for Cutter Penicillin in Oil and Wax, in either of two strengths . . . 100,000 or 200,000 units per cc., each available in 5 cc. bottles. Cutter Laboratories, Berkeley, Calif., Chicago, New York.

*Than other oil and wax suspensions
†Than other animal or vegetable oils

ESPECIALLY VALUABLE

Because of its Basic Nutrients

Anorexia during some period of a child's life is not an uncommon occurrence, although distressing and disconcerting to the mother. If permitted to continue uncorrected, poor eating habits result in undernutrition, manifested by underweight, poor resistance to infectious diseases, irritability, and emotional outbursts. That mothers seek aid for the eradication of this condition is only logical.

An increasingly larger number of pediatrists are recognizing the value of Ovaltine in overcoming poor nutritional states. This delicious food drink, made with milk as directed, supplies a wealth of basic nutrients: biologically adequate protein, readily metabolized carbohydrate, and highly emulsified fat. In addition it provides B complex and other vitamins, and essential minerals. Three glassfuls daily enhance the intake of these nutrients to a significant degree, as indicated by the table below. And, of especial advantage when dealing with children, Ovaltine is attractive to the palate, and is taken by all younger patients with relish and joy.

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PROTEIN	31.2 Gm.	VITAMIN A	2963 I.U.
CARBOHYDRATE	62.43 Gm.	VITAMIN D	480 I.U.
FAT	29.34 Gm.	THIAMINE	1.296 mg.
CALCIUM	1.104 Gm.	RIBOFLAVIN	1.278 mg.
PHOSPHORUS	.983 Gm.	NIACIN	7.8 mg.
IRON	11.94 mg.	COPPER	.5 mg.

*Based on average reported values for milk.

of the constitution of 1936, "is insured by the wide development of social insurance of workers and other employes at state expense, free medical service for the working people, and the provision of a wide network of health resorts at the disposal of the working people."

All health activities are administered by the People's Commissariats of Public Health and their subsidiary organs. The commissariats are in charge of sanitation and the control of communicable diseases. Sanitary inspection is one of their very important functions. The commissariats, furthermore, control hospitals, health centers, rural health stations, nurseries, sanatoria, health resorts, pharmacies, etc., and the services they render. They also control the training of medical personnel. The number of medical schools was increased from thirteen in 1913 to fifty-one in 1941, training 106,000 students. At the time of the first Five-Year Plan 75 per cent of all medical students were women. The percentage decreased somewhat after 1932, but increased again during World War II, and there can be no doubt that the number of women engaged in medical work will exceed the number of men in the very near future.

Women are holding leading positions in every field of medicine, and I can say they are doing a marvelous job. The commissariats are also responsible for producing the equipment required for the health work of the nation. They, therefore, control the medical industries, such as the pharmaceutical industry and those that produce instruments, apparatus, appliances, and other medical commodities. The administration of health is carried out very democratically under the broad participation of the entire population. Factories, farms, and other working places have health committees that cooperate closely with the health agencies, take an active part in the planning of health and in the carrying out of health measures.

The promotion of health and prevention of illness are in the foreground of all Soviet health activities. A vigorous campaign of health education is carried out permanently throughout the country and the health educational program has been unusually successful because it went hand in hand with education in citizenship. Once the view was held that health and sickness are not a private matter of the individual and the citizen became aware of his responsibility toward the community, health education fell on fertile ground.

The development of physical culture on a mass scale was another measure that greatly contributed to the promotion of health, and so has the systematic organization of rest and recreation. Not only have all the workers vacations with pay, but they have many institutions available where they can spend their vacations in a way that will benefit their health: rest homes, vacation camps, health resorts in the country, at the seaside, and in the mountains. All such institutions have medical personnel attached to them so that minor ailments can be remedied before serious illness develops.

Special preventive measures have been developed for the protection of those individuals who physiologically or socially are particularly threatened. Thus from the very beginning great attention was paid to the protection of motherhood, in-

You Deserve It!

Last word in sterilizer beauty and efficiency is this Pelton Model 61-HP . . . Roomy . . . Impressive . . . Finished like the finest motor car . . . All the clever features you've admired, plus some more you've never heard about . . . Topped by the famous 8 x 16 Pelton Surgical Autoclave that sterilizes gloves, fabrics and other materials with 250 degrees of steam under pressure . . . Just what you've always wanted—and deserved . . . Your dealer can accept your order today.

Double Cabinet less Autoclave, $192. With Autoclave as shown, $482. Same plus 2-gal. Water Sterilizer, $571.50. Western prices $203, $503 and $579.50 respectively.

THE PELTON & CRANE CO.
Established 1900
Detroit 2, Michigan

Pelton STERILIZERS

fancy, and childhood. Not only was every former discrimination against women abolished, but special protection was extended by law to pregnant and nursing women. The country has today 5,803 women's and children's consultation bureaus where women can obtain advice and aid for themselves and their children in all their physiological and pathological problems. Over one-half of all children are born in maternity homes.

The protection of labor, the creation of the best possible working conditions, is the responsibility of the trade unions, a task in which they cooperate very closely with the health authorities.

In 1941 the USSR possessed 13,461 urban medical centers, 13,512 rural medical centers, in addition to about 35,000 smaller rural medical stations. They are all administered by the health departments, and in the cities are connected either with the working places or residential districts. There are various types of health centers, small ones to serve small groups of about 10,000 people; larger, the polyclinics, to serve groups of 50,000, sometimes up to 100,000 population. The tendency is now to have centers serving about 50,000 population.

The principle that prevails in the provision of medical services to the urban population is also applied to the rural population, with certain modifications. All medical workers are in the government service. Although private practice has never been forbidden, it has practically died out. The doctors are salaried, and their salaries are determined by three factors: experience, responsibility, and hazard. This is why rural physicians have salaries from 10 to 20 per cent higher than those of urban doctors in corresponding positions, because the job is a tougher one. All doctors have at least four weeks, vacation a year with full salary. Their professional advancement is assured by frequent post-graduate courses.

Medical research is carried on vigorously in 223 research institutions, staffed with more than 20,000 medical scientists, and it is generally known by now that very important scientific contributions have come from Russia during the last twenty years. —HENRY E. SIGERIST, M.D.

Weak Feet, Strong Mind

The young woman had flat feet. I prescribed metal arch supports, told her where to buy them, and asked her to return later so that I could check on their fit. Several weeks elapsed before she came in, complaining that her feet hurt even more than before. Upon examination, I saw why: She had been wearing the left plate in the right shoe and vice versa. "No wonder they hurt," I remarked, switching the plates. "Now try them." She took a few steps around the room, shook her head impatiently, and sat down. Then she hauled off her shoes, switched the plates back, and flounced out of the office. I never saw her again.

—M.D., NEW JERSEY

How to Index Your Medical Reading

Two easy ways to assemble a file that beats the best memory

Even if much of it has no permanent value to you, some of the reading matter you go through each week may be genuinely useful later—for the treatment of a difficult case, perhaps, or in the preparation of a paper or lecture.

How to preserve such portions—and have them readily available when you want them?

There are two simple ways to do this. One—the clipping method—permits you to discard back issues of medical journals after clipping the items you wish to keep. The other—the card index method—is for physicians who wish to preserve back issues intact for an indefinite period.

Either method takes but a little of your time. Both employ the simplest and most practical form of index: subject matter in alphabetical arrangement. Both, therefore, involve the use of a comprehensive authority list of medical subject headings.

For the average G.P., the subject index of the Journal AMA, which appears therein three times a year (at the end of April, August, and December), will serve nicely as a guide in selecting a list of subject headings. For the specialist, a yearly index is usually available in the national journal covering his field, and he may find it a valuable adjunct to the JAMA subject list. A physician whose reading is extensive may want to obtain the "Quarterly Cumulative Index Medicus: Subject Headings and Cross References" from the AMA. Again, the "Standard Classified Nomenclature of Disease," which many physicians own, has an excellent index which can be used as a subject-heading guide.

CLIPPING METHOD

Here you maintain a file of letter-size folders in which articles clipped from medical journals can be filed after being properly classified. A separate folder is devoted to each heading selected from your subject-heading guide and each folder is filed alphabetically. Thirty to fifty folders would probably cover the range of subjects which interest the average physician, but any number may of course be used.

For culling material of permanent value, a five-step procedure is recommended, with the office assistant attending to most of it in this manner:

Function	Done by
Clip	Assistant
Mark (source and date)	Assistant
Select	Physician
Classify (by subject)	Assistant
File	Assistant

A competent assistant can often be entrusted with the fourth step

Compare THESE 2 ELASTIC BANDAGES

ACE NO. 1

ALL-COTTON . . . WITHOUT RUBBER

Should be compared *only* with all-cotton elastic bandages.

This original Ace is the standard all-cotton elastic bandage and has proven its therapeutic value in many thousands of cases of varicose veins and ulcers, strains, sprains, and injuries.

Made from long-fibered Egyptian cotton with properly twisted warp and weave, it has an adequate quantity of cross threads to provide substantial body. These specifications assure moderate, uniform stretch over the full width of the bandage. Cool and comfortable to wear due to its porous weave. Washing restores elasticity.

ACE NO. 8

*SKIN-TONE . . . WITH LASTEX**

Should be compared *only* with rubber reinforced elastic bandages.

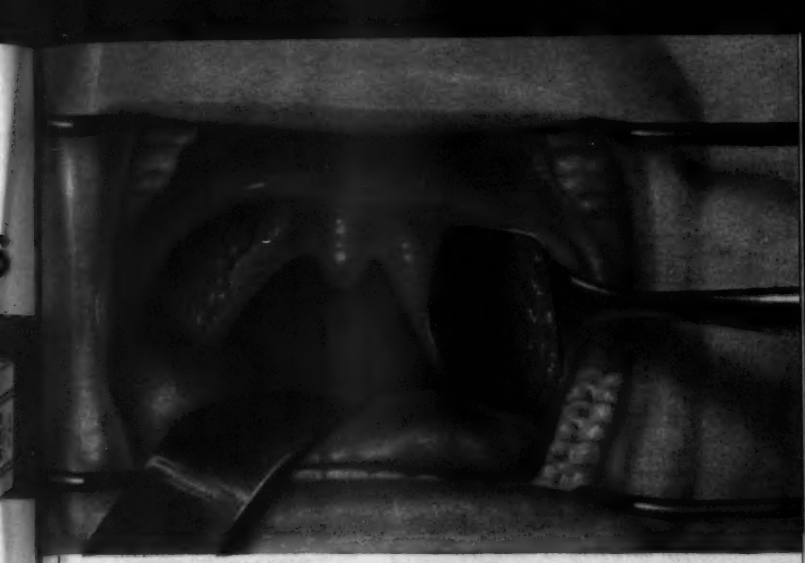
Preferred where motion of the part wrapped may cause slipping or loosening of the bandage.

Ace No. 8 assures constant elasticity because it is reinforced with "Lastex"* yarn. It has been designed to remain elastic and useful — comparatively unaffected by dealer storage, perspiration, oils, grease and solvents that may shorten the life and reduce the therapeutic value of rubber reinforced bandages. A woven "brake" controls the stretch, adding to the stability and life of the bandage.

*Reg. U. S. Pat. Of

B-D PRODUCTS
Made for the Profession

BECTON, DICKINSON & CO., RUTHERFORD, N. J.



PROVIDING COMFORT AND SHORTENING CONVALESCENCE FOLLOWING TONSILLECTOMY

Chewing Aspergum promptly releases a soothing flow of saliva laden with acetylsalicylic acid. Thus the analgesic is brought into *immediate and prolonged* contact with pharyngeal areas often not reached, even intermittently, by gargling or irrigation.

The rhythmic stimulation of muscular action aids in relieving local spasticity and stiffness—more rapid tissue repair is promoted.

Because the patient is more comfortable, an adequate diet is assumed and maintained earlier—convalescence is shortened.

Each agreeably flavored chewing gum base tablet provides 3½ grains acetylsalicylic acid. This moderate medicinal content permits frequent use. Particularly suitable for children.

Packages of 16. Moisture-proof bottles of 36 and 250 tablets.

Ethically promoted—not advertised to the laity.

White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.

Dillard's **Aspergum**

that of marking the clippings for subject classification; but the physician may wish to attend to this himself. In either case, strict adherence to his list of headings is obviously necessary; for a file would soon become worthless if one article were classified as "Conjunctivitis" while another on the same subject were indexed under "Eye Diseases."

It is well to adopt at the outset a definite system for handling subject headings. Cancer, for example, is so important that a single folder may soon become bulky with clippings; whereupon it will be necessary to subdivide the subject into such categories as "CANCER—Etiology," "CANCER—Research," and "CANCER—Treatment." So in marking your tear sheets, develop the practice of writing your headings in the manner—with the key subject first, followed by the sub-classification.

Pencil your subject heading (or let your assistant write it) in the top right margin of the page on which the article starts. (The top *left* margin, when the clipping comes to you for reading and selection, will already have been marked by your assistant with the name of the publication and date of issue—unless these references appear in the printed matter itself.)

Points for the assistant to bear in mind in carrying out her part of the procedure are:

1. Name of publication and date

"SHOULD HE WANT TO INVITE DOROTHY LAMOUR, BETTY GRABLE, AND HEDY LAMARR TO HIS BIRTHDAY PARTY?"

Fast action

Asthmatic and hay fever patients usually experience relief wi
15 minutes after taking a Tedral tablet. Tedral relaxes the bronc
muscles, reduces swollen membranes and facilitates expectorat
Adult Dosage: 1 or 2 tablets three times daily. In 24's, 120's
1000's—also Tedral Enteric Coated for delayed action during sl
The Maltine Company, New York. Established 1875.

TEDRAL *for relief in asthma and hay fever*

of issue should be recorded on every clipping unless the printed matter itself includes these references. Top left corner is the best place to make such notations leaving the top right margin for subject classification.

2. When in doubt about the value of an item, clip it anyway. The doctor can easily discard it in the screening process if it isn't important to him.

3. Before you clip any item, look on the reverse side of the page. If it carries a second item of potential interest which will be lost by clipping the first, make a typewritten copy of one or the other—being sure to indicate source and date. Or get a second copy of the periodical, if that is possible. Don't try to decide which is the more important; play safe—provide both.

4. If the clipped item is a short one—if there is any danger that the clipping may be lost—paste it onto a larger sheet of paper. Or cut out the entire page and blue-pencil the item of interest. Again, don't forget source and date.

5. If you have to clip more than one page to secure an article in its entirety, staple the pages together in their proper sequence.

6. Best tool to use in clipping is a Gem-type razor blade.

The physician's screening function (Step 3) can be eliminated if he adopts the plan of *indexing as he reads*. This merely means penciling in the proper subject heading whenever he comes upon an article of future worth in any journal he happens to be reading. In other words, instead of allowing his assistant to make the initial selections, he first scans the journal himself; and his penciled notations, when the journal goes to the assistant, indicate which articles he wants clipped. (As a further signal, he may dog-ear the pages.) The procedure:

Function	Done by
Classify (by subject)	Physician
Clip	Assistant
Mark (source and date)	Assistant
File	Assistant

If the initial selection of material is left to the assistant, the doctor must not only expect to screen out the over-matter but must run the risk of having the assistant occasionally overlook an article or news item of real value.

The clipping method also provides a repository for abstracts of books, for notes made at the library or at medical meetings, for mailing pieces received from pharmaceutical houses, for public health bulletins, Government pamphlets, newspaper clippings, and other such matter. Anything, in fact, which can be filed in a regular letter-size folder may be handled by the clipping method described.

CARD-INDEX METHOD

This method requires the maintenance of a file of 3″x5″ cards, on which proper reference to medical journal articles is marked. The cards, like the clippings, are filed alphabetically according to subject; and the journals are kept intact and filed chronologically (and bound periodically, if that is desired). A separate card is made out for each article of importance—thus:

> CONJUNCTIVITIS—Treatment
> Selinger, Elias.
> Dermatitis of the lids from penicillin drops.
> JAMA 128:437 June 9, 1945

In other words, each card carries these entries: (1) subject heading

—assigned, as in the case of the clippings, through the use of an authority list of headings; (2) author's name; (3) title of article; (4) name of publication, date of issue, and page number.

Here, again, the physician may adopt the plan of indexing as he reads. To jot down the above entry on a card takes but a moment. In the same way, a pamphlet, a book, or any chapter of a book can be similarly indexed as it is read—in the office, at home, in the library, or while traveling.

Otherwise, the cards may be made out by the office assistant. In this case, the physician may indicate which articles he wishes to have indexed by penciling in his subject classifications in the journal at the time he scans it. The assistant's part of the procedure then becomes a mere job of copying the data onto the cards and filing them.

ABOUT EITHER METHOD

Always be as specific as possible in the assignment of subject headings. "Heart Disease," for instance, may be adequate for *general* articles on the subject—but one on a specific heart ailment, such as angina pectoris, should be indexed by its specific name. Avoid the use of such headings as "Miscellaneous" and "General Medical." When in doubt, let your subject list be your guide; or ask the advice of a good librarian.

If an article covers two or more subjects, multiple indexing becomes imperative. Such an article would naturally be "prime-indexed" under its key topic. Using the clipping method, memorandum notations should be filed under each additional topic, indicating in which folder the actual clipping may be found. Using the card system, an additional card would be necessary for each subject covered in the article.

Cross references—which at first may seem a little burdensome—are an important feature of any good index. There are two kinds: the "See" reference and the "See also." The former is a device for simplifying things. For example, in a clipping file, instead of having folders for both "Adrenalin" and "Epinephrine" (terms that are often used interchangeably), you need only an "Epinephrine" folder. Under "Adrenaline" you would merely have a guide card, "See Epinephrine."

The "See also" reference enables you to find quickly other subjects closely allied to the one you are looking up at the moment. Thus, your "Industrial Accident" folder would carry the notation, "See also Workmen's Compensation."

Don't try to index too many articles; select only those which have a definite importance to *you*. Leave as much of the detail as possible to your office assistant—but handle the assignment of subject headings yourself until your office girl fully understands the procedure.

—NELSON ADAMS

Show-Off

I had just pronounced him dead, when, to my chagrin, he suddenly sat up in bed. "Lie down," his wife ordered. "Who knows better—you or the doctor?"—MORRIS WOODROW, M D.

A new DEVELOPMENT IN TOPICAL OTOLOGIC THERAPY

Presenting a stable, non-irritating solution of sulfanilamide, urea and chlorobutanol in a glycerin vehicle of unusually high hygroscopic activity. Otomide offers these definite clinical advantages:

IN VIVO ANTIBACTERIAL POTENCY—not inhibited by pus.

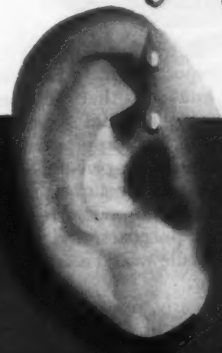
POTENTIATED ANTIBACTERIAL ACTIVITY—urea-sulfanilamide mixture more effective than either drug used independently.[1]

WIDE FIELD—effective in BOTH acute AND chronic otologic infections. Active against sulfonamide-resistant bacteria.[2]

TOLERANCE—freedom from alkalinity—virtually obviates local irritation.

ANALGESIA—effective chlorobutanol analgesia without impaired sulfonamide activity.

1. *Tsuchiya, H. M. et al.: Proc. Soc. Exp. Biol. and Med., 50:262, 1942.*
2. *Strakosch, E. A. and Clark, W. G.: Minn. Med. 26:276, 1943. Brown, C. et al.: Am. J. Surg., to be published.*



White's

OTOMIDE

Formula

SULFANILAMIDE 5%
CARBAMIDE (Urea) 10%
CHLOROBUTANOL 3%
GLYCERIN (high sp. gr.) . q. s.

Sidelights

The Nov. 30-Dec. 1 meeting of the AMA Council on Medical Service and Public Relations laid the groundwork for a national voluntary medical plan in opposition to the Wagner-Murray-Dingell bill. The meeting was without question the most important one held by the council up to that time.

Despite that fact, nineteen state medical societies failed to have representatives present.

What a member of the Senate Military Affairs Committee refers to as the "growing rift" between medical officers and their medical societies calls for some stock-taking on both sides.

There is no doubt that a number of societies *have* let the medical officer down and should do something about it. On the other hand, some medical officers who allege that their societies don't give a damn about them have simply failed to investigate what the societies *are* doing in their behalf.

It's our impression that the weight of the evidence is probably on the side of the physician in service. But generalizations about the subject get us nowhere.

Have you a diffenbachie in your office? You should have.

Our first encounter with a diffenbachie was in the suite of Dr. W. L. Tucker, in New York City, where there is a peachy one, 2½ feet tall.

The diffenbachie, you'll be interested to know, is not a species of East Indian mongoose, but a kind of West Indian plant, known also as "dumb cane." It gets its name, Dr. Tucker tells us, from the fact that if bitten it induces a paralysis of the tongue which lasts several days. Planters, he says, compelled their overtalkative slaves to bite it.

If in our next visit to Dr. Tucker's office we see Mrs. McChatter with a twig instead of a thermometer between her teeth, our suspicions will be confirmed.

An important fact, yet one not widely known, is that the amended Hill-Burton hospital construction bill authorizes appropriation of Federal funds for private, sectarian as well as nonsectarian hospitals. Tax funds are supposed to be spent for public purposes, and departure from this rule would establish a bad precedent.

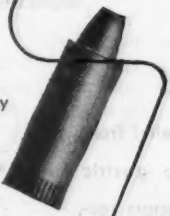
There are powerful forces at work now to break down the American principle of separation of church and state. This was evident in Senate testimony on S.717 and S.181, the education finance bills.

Practically every state constitution has a prohibition against the utilization of state or local funds or credit for sectarian institutions. Yet in the Hill-Burton bill it is pro-

a less irritating
vasoconstrictor—

"a benzedrine inhaler is probably the least irritating of any method for shrinking the nasal mucosa..."

a better means of nasal medication



Benzedrine Inhaler, N.N.R., does not give rise to any significant degree of secondary turgescence, atony or bogginess, when used as directed. Furthermore, according to Proetz, it causes "no appreciable change in the amplitude or rapidity of the ciliary beat." The Inhaler produces a shrinkage of the nasal mucosa equal to, or greater than, that produced by ephedrine. Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 200 mg.; menthol, 10 mg.; and aromatics. Smith, Kline & French Laboratories, Philadelphia, Pa.

BENZEDRINE INHALER

Quick

Pleasant

Relief

For quick, pleasant relief from stomach upset due to gastric hyperacidity, many doctors recommend BiSoDoL, the effective antacid alkalizer.

May we suggest that you try BiSoDoL in your practice? It is carefully compounded, thoroughly dependable, medically accepted.

BiSoDoL

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WHITEHALL PHARMACAL COMPANY

22 EAST 40th STREET
NEW YORK 16, N. Y.

posed to permit the Surgeon General to deal directly with sectarian groups, paying Federal funds to them instead of directing the funds through state agencies. This is a new technique.

We may as well throw the state constitutions out the window if they are to be circumvented by taking tax funds out of the states, channeling them into the Federal Treasury, and then redistributing the funds to the states without regard to state prohibitions against the use of public funds for private purposes.

A New Jersey G.P. writes that his pet peeve is the patient who, when asked, "What seems to be the matter?" answers, "That's for you to find out."

Instead of discontinuing the use of the question that brings this reply, our correspondent says he enjoys "getting back at smart alecks." When one tells him, "That's for you to find out," he makes this stock reply:

"If that's the case, I'm afraid I can't help you. I'll have to send you to a specialist who asks no questions of his patients because they're all dumb and can't explain what's bothering them—in other words, a veterinarian."

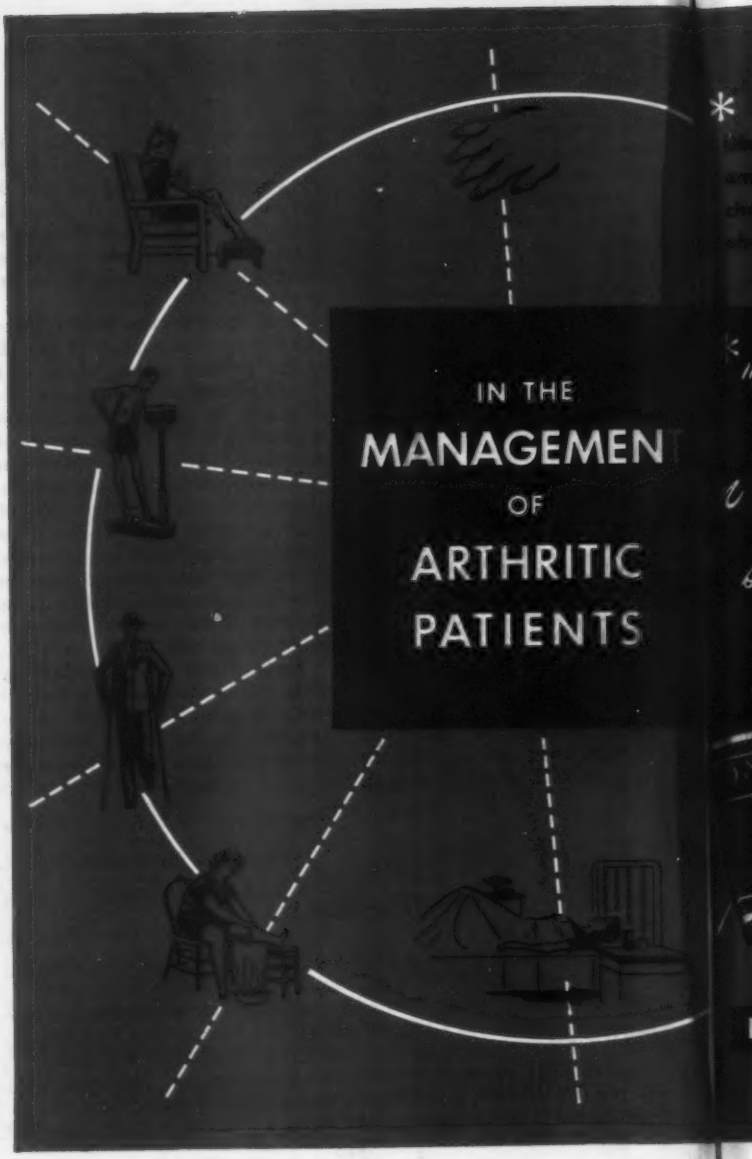
Medicine's hecklers allege that since only 1½ per cent of the American people have subscribed to medical society prepayment plans in the last few years, such plans cannot do the job. Compulsory sickness insurance, they conclude, is the only answer.

These people close their eyes to (1) the accelerating rate of growth of the medical society plans, (2) the likelihood of still greater acceleration as national coordination is effected, and (3) the record of individual plans (*e.g.*, Michigan and Washington) in having already saturated as much as 20 per cent of their potential market. The Blue Cross voluntary effort has of course shown even more striking gains. In Cleveland, for instance, Blue Cross coverage of its potential market is about 86 per cent.

These things show conclusively what can be done when a real attempt is made. They offer an inspiration to the many voluntary health plans now planned or under way.

Horning In

At 3 A.M. my next door neighbor tapped on my bedroom window. "Come quickly," he urged, "my wife's having her usual bout with asthma." I dressed hurriedly, ran to get my emergency bag from the car. Just as I left the garage, the horn let out a nightrending blast. Never in my life have I been so startled. As I stood there shaking, something moved near the wheel, and I got ready to run. I would have, too, but at that moment a huge black cat sprang out of the car and beat me to it. —H. L. KERR, M.D.


IN THE
MANAGEMEN
OF
ARTHRITIC
PATIENTS

A Comprehensive, Basic Plan for Collecting Medical Bills

Have a competent aide and make her responsible for your accounts

Do you send statements monotonously month after month, lull the debtor into lethargy, and then after a year or two when the account is practically hopeless, turn it over to an agency? If so, it's time to slipstream your credit procedure.

You can't afford to let passive statements put whiskers on your accounts. Naturally you want to keep business matters between you and your patients as impersonal as possible, so you instruct your secretary to send statements. But they alone are not the answer. From the third to the eighth month is the crucial period when you should be getting in your best licks with progressive pressure applied painlessly but consistently.

Begin by developing a secretary who can serve as a first-class credit manager and take *full responsibility* for credit relations with your patients. Such an aide should be able to write letters over her own signature, follow them up, make telephone calls, and confer with patients to arrange payments. You will of course guide her in matters of policy and help her plan improvements in her program, but you will do well to stay out of the picture otherwise until the very last stage of the collection procedure. Then, if you do have to come in, a few letters over your signature pack an added wallop, and your weight is applied where it is most needed.

Your Girl Friday already knows how to meet people and how to reflect the atmosphere of a professional office. But she will need pointers on credit psychology, such as those which follow.

Pride will be her most effective target. If she stimulates it, or gently pricks it, she gets favorable action. If she injures it she gets nowhere. She must learn how to save face for the debtor and help him keep his self-esteem.

This is her program:

PART ONE

She actually begins her collection preparations the first time the patient walks into your office. The routine registration brings out quite casually, in addition to name, address, and phone number, his occupation and who referred him. Later she will use the city directory and telephone book for verification. She notes down her observations on his appearance, manner, and speech as clues to his economic standing and character. If the first visit is a house call, she gets as much registration data as she can by phone, and the doctor supplies the rest on his return to the office.

Finally, she clears the name

through a credit bureau (the medical bureau, certainly, and, if possible, a general retail bureau, too). This elicits information on paying habits and helps spot known delinquents in advance. She keeps a file of all this information on each patient, making changes and additions as required. The file is her guide in separating the good risks from the doubtful ones and in applying collection methods tempered to each.

PART TWO

Your aide initiates and follows through on the collection steps shown below, pacing them fifteen days apart at first (a month is much too long), ten days apart in later stages, and eight days apart at the last. For those known in advance to be quite slow she accelerates the whole tempo. To known deadbeats the doctor's terms are cash.

The usual schedule:

First month: statement, no comment.

First and fifteenth of second month: statement with printed sticker making routine collection appeal.

First of third month: statement with penned or typed note signed by secretary, saying, "Early payment will be appreciated."

Fifteenth of third month: letter signed by secretary to stimulate pride, saying, "I was confident that we would hear from you by this time . . ." and closing with direct request.

First of fourth month: follow-up letter by secretary proposing conference to discuss debtor's problem and to arrange series of payments; letter expresses confidence, saying, "I know you want to get this matter straightened out."

Fifteenth of fourth month: secretary writes, "The doctor has asked me to call your attention . . ."; the debtor learns thus that his delinquency is growing conspicuous, that the doctor has an eye on it; the letter asks for payment or a conference.

First of fifth month: secretary telephones to say, "The doctor feels that something concrete should be done about your account immediately"; this is vague enough to hint trouble; secretary tries for full payment and, if she doesn't succeed, presses for a promise of part payment at a definite date (not more than ten days) and extracts a commitment on the balance. If the debtor has a real problem, she invites him in for a conference.

Tenth and twentieth of fifth month: follow-up telephone calls (if there is no telephone, registered letters are substituted).

PART THREE

If the patient comes in to arrange payment as a result of any of these

Handitip

Accident Losses Cut

My greatest losses in medical fees used to result from the treatment of injuries received in accidents. Now, such losses are negligible. When an accident victim is brought to my office and is able to write, I tactfully request that, before leaving, he sign the following form:

I, _____, hereby request the services of Dr. _____ on _____ at _____ and promise to pay in full a reasonable fee for such services rendered.

Signed _____

Such a document may not be legally necessary. But in actual practice it gives me a hold on accident patients which they apparently respect.

—M.D., ILLINOIS

Complete for Secondary Anemia

IRON

LIVER

VITAMIN B COMPLEX

Elixir Li-Betaferron is a hematinic and tonic for the treatment of secondary anemias; complete with readily assimilable iron—whole liver concentrate—vitamin B complex in a new high potency. Check the Li-Betaferron formula—each fluidounce contains:

Alcohol 10%

Liver Concentrate 1:20	1.42 Gm. (21.875 grs.)	Riboflavin	6 mg.
Iron & Ammonium Citrates, Green	2.00 Gm. (30 grs.)	Nicotinamide	60 mg.
Thiamine Hydrochloride	18 mg.	Pantothenic Acid	45 mg.
and the other vitamin B complex factors as present in liver.		Vitamin B_6 (Pyridoxine)	1.8 mg.

WARREN-TEED

Medicaments of Exacting Quality Since 1920

THE WARREN-TEED PRODUCTS COMPANY, COLUMBUS 8, OHIO

Warren-Teed Ethical Pharmaceuticals: capsules, elixirs, ointments, sterilized solutions, suppositories, tablets, Veins for Intravenous

appeals, the secretary invites frank discussion, draws out complete information about his economic situation, gets the *debtor* to say how much he can pay, and works out a definite schedule with him. If he promises too much, she is tactful but realistic, scaling the figure down and then holding him to it when he starts making remittances.

(This technique is applied, too, when Mrs. Jones needs an operation, and Mr. J. says in dismay he has no money for it: Your secretary-credit manager goes into his situation with him tactfully but thoroughly, works out payments within his means, and refers him to a reputable banking agency that will finance the hospital bill. She cooperates with the banking agency to see that combined arrangements are realistic.)

PART FOUR

Here is where *you* come in, provided Part Three never happens:

You send the debtor two man-to-man letters, spaced eight days apart. These express strong confidence in human nature and in the patient's good intentions despite appearances. They show him he is now in a minority group where he doesn't belong. You ask for a check in full. If he should come in and ask for a conference with *you*, call in your secretary after it is finished, and tell her in his presence what the arrangements are, so there will be no "misunderstanding" if she has to follow him up.

PART FIVE

If all this meets with no response at all, the account is ripe for a collection agency. But don't turn it over until you have written a final letter giving fair notice and allowing the patient a chance to come in and pay direct by a specified date.

—H. F. SOMMERS

Quiz

[Answers on page 134]

1. When you say the patient's face is "livid," you mean
   a. Red b. Yellow c. Black and blue d. Pock-marked
2. The words Permanente Foundation have reference to
   a. A special concrete foundation for hospitals
   b. A medical care plan for industrial workers
   c. Scholarships in industrial medicine
   d. Research opportunities in pediatrics
   e. An abdominal support for the obese
3. The Fifth MEDICAL ECONOMICS Survey indicates that the highest average gross income among specialists in 1943 was earned by
   a. Neuropsychiatrists b. Ophthalmologists c. Surgeons
   d. Roentgenologists e. Obstetrician-gynecologists
4. X-rays have been used by doctors for the past
   a. Four centuries b. Three centuries c. Two centuries
   d. Half century e. Quarter century
5. Profeta's law, say those who should know, concerns
   a. Enzyme action b. Blood coagulation c. Congenital lues
   d. Income tax deductions e. Health insurance rates
6. The letters DDT are an abbreviation for the words
   a. Douglas D. Thorndike b. Delta-doryl-tonsorium
   c. Double delirium tremens d. Dinitro-dibenzyl-toluene
   e. Dichloro-diphenyl-trichlorethane
7. First recorded use of digitalis (foxglove) in dropsy was that suggested to a doctor by
   a. A medicine man in Bantu b. A mandarin in Canton
   c. An old man in Brooklyn d. A woman in Shropshire
   e. The magician at King Arthur's court
8. Reginald Fitz will long be remembered for his work in
   a. Typhoid fever b. Yellow fever c. Appendicitis
   d. Meningitis e. Alcoholism f. Hypnotism
9. Economists say that when buying a home you should pay on the average, no more than the following times your annual net income:
   a. 2/3 b. 1 2/3 c. 3 d. 3 2/3 e. 5

Choosing the Right Office Aide

Some hints on sizing up the qualifications—or lack of them—in a job applicant

You're taking on a new secretary (or medical assistant, or nurse, or receptionist, or technician). You have the names of several applicants; some have answered your want ad, others have been suggested by a school or employment agency. You're ready to start the interviewing. How to do it—wisely?

Decide at once to eliminate all but the most likely candidates. Their letters of application—or data supplied by the agency—should indicate the best three or four.

When you invite each girl, via phone or letter, to come in for an interview, ask her to bring along a resume of her schooling and experience—if she hasn't already supplied one—together with any letters of recommendation she may have. If possible, spread the interviews over several days. Seeing too many applicants on the same day crowds your schedule, doesn't give you time to mull over the qualifications of each girl.

Commercial practice calls for a questionnaire to be answered before an interview is granted. Have your applicants fill in a similar form at your office *after* you've met them. Reason: The girl's duties will include the handling of various forms, and her ability can be measured by the way she fills in your blank. If she finds it confusing, or appears to need coaching, she may not be the jewel you seek.

Your application form should elicit the following data: applicant's name; her address and telephone number; date and place of birth; marital status; present employer; present salary and salary desired; schooling; complete chronological summary of experience; reason for leaving each previous position; references; date of application.

Be sure to find out whether your applicant is married or single, widowed or divorced, and how many dependents she has. Such factors bear on (a) her willingness to work overtime and to adjust her life to an exacting schedule; and (b) her peace of mind about financial obligations. If she isn't married, is she planning to be in the near future? If so, will she continue working? If married, is she likely to quit her job soon?

Some application blanks include a question about health. Others ask, "Any physical handicaps?" As to religion, don't forget that there are

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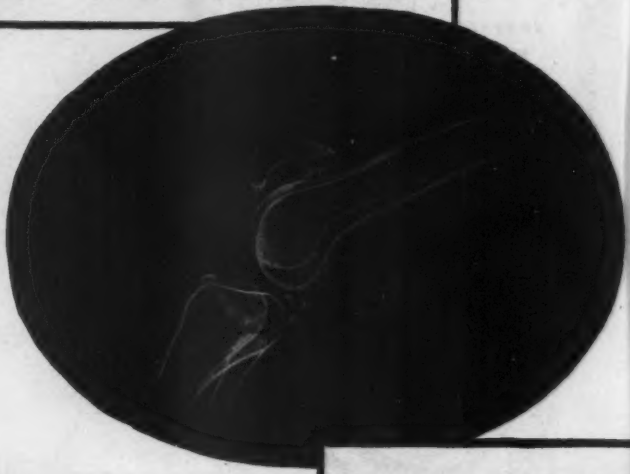
▶ This is the second of two articles on the employment of office assistants. The first, which appeared last month, covered sources of supply.

IN THE TREATMENT OF ARTHRITIS



SUGGEST SUPPLEMENTARY HOME-MASSAGE WITH MINIT-RUB

Massage with MINIT-RUB increases local blood and lymphatic supply thereby bringing symptomatic relief to aching joints.

Counterirritant, analgesic, decongestant, MINIT-RUB is also effective in simple neuralgias.

Recommend **MINIT-RUB** *to your patients.*

THE MODERN RUB-IN

STAINLESS • GREASELESS • VANISHING

A Product of **BRISTOL-MYERS COMPANY**

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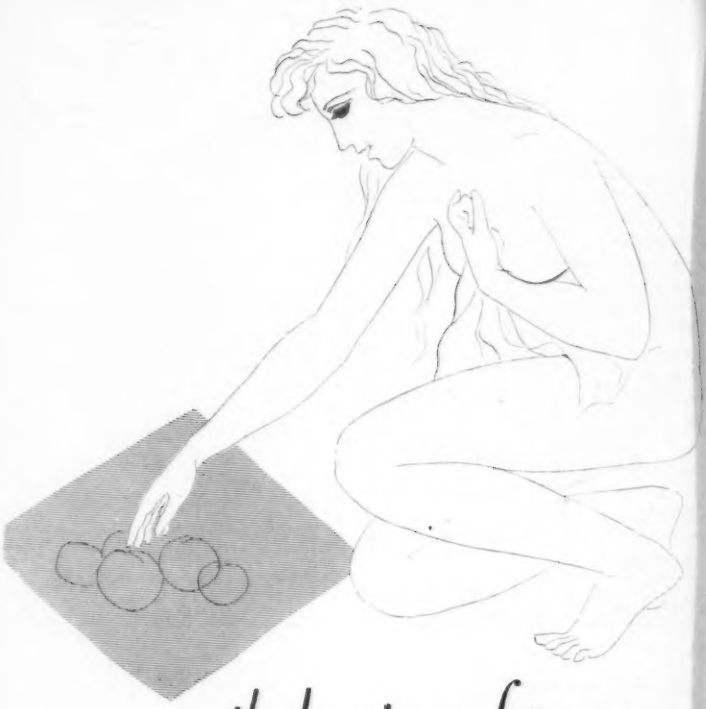
Three not thirty

Just 3 drops of Navitol, not the 5 to 30 drop dosages of less potent preparations, supplies the full basic daily requirements of both vitamins A and D. Highly concentrated Navitol is easy to take, well tolerated, effectively absorbed and economical. Three drops supply 5,000 units of vitamin A, 1,000 units of vitamin D — the maximum potencies as specified by XII.

Navitol
TRADEMARK
WITH VIOSTEROL

SQUIBB

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858



the longings of pregnancy

The vagaries of a pregnant woman's appetite can sometimes play havoc with the carefully planned diet you've prescribed. And so a supplementary intake of calcium is indicated. The simple addition of Squibb's Dicalcium Phosphate with Viosterol, two capsules daily, affords a total of 7.8 grains of supplementary calcium (about half the daily requirement) with more than sufficient vitamin D to assure its utilization.

Dicalcium Phosphate Compound
WITH VIOSTEROL

SQUIBB

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Check List of Personal Characteristics

Applicant .....

Position..... Date.....

Characteristics	Satisfactory	Unsatisfactory	Comments
Eyesight			
Hearing			
Teeth			
Voice			
Posture			
Complexion			
Hair			
Nails			
Odors			
Cosmetics			
Alertness			
Poise			
Language			
Tact			
Judgment			
Industry			
Friendliness			
Temperament			

AN *Aid* TO NATURE *in* CORRECTING CONSTIPATION

KONDREMUL—the Irish Moss and mineral oil emulsion—provides a non-irritating, lubricating agent, softens the fecal mass, thus promoting smooth, natural elimination.

KONDREMUL maintains an even dispersion all the way through the gastrointestinal tract.

Physicians depend on Kondremul for resistant cases, atonic constipation and simple constipation.

Supplied in three forms, Kondremul provides a gradation of treatment for all types of constipation:

Kondremul Plain—for simple constipation.

Kondremul with non-bitter Extract of Cascara—for prolonged laxation.

Kondremul with Phenolphthalein* (2.2 grs. phenolphthalein per tablespoonful)—for the resistant case.

**Caution: Use only as directed.*

Canadian Producers: Chas. E. Frosst & Co., Box 247, Montreal, Quebec.

THE E. L. PATCH COMPANY, Boston, Mass.

such things as anti-discrimination laws; that in some states you may not even ask an applicant what her religion is. In sum, watch your step on this point.

When interviewing a candidate, have before you a list of the personal qualifications important to your work. Such a list accompanies this article (extra copies available on request). As soon as the applicant has left, make your entries in the spaces provided. At first glance, this may seem like a lot of work; actually, it will take but a few moments—and it will be invaluable in making comparisons after you have interviewed two or three people.

You will naturally also use your talents as a physician in sizing up each applicant. Does she appear frail and sickly? Is she nervous and fidgety? Has she any outward signs of disease?

In scanning letters of recommendation, remember that friends are often overenthusiastic. Statements in such letters—even if they come from colleagues—should be weighed against your own impressions, and checked, if necessary, by phone calls to the writers.

The applicant's resume, in itself, may tell you something of her competence. How well is it organized? Is it neatly typed? Is it complete? Is there variance with facts set forth on the application blank or in letters of recommendation?

Early in the interview, tell the applicant what hours she will have to work and outline the duties involved. Describe, frankly, the less agreeable aspects of the job—and ask her if she is still interested. (A registered nurse, for example, may think it below her dignity to run errands, take mail to the post office, etc.) Explain, too, there will be emergencies, overtime, and so on, and that you will expect her to cooperate cheerfully at such times. Be sure she understands these matters, and get her to agree to them.

Question her in detail about her education. From the type of schooling she has had, you can tell a good deal about her family background. From the kind of courses she herself has elected to take, you can gauge her interests and ambitions. Make it a point to ask why she wishes to be a medical aide; her reasons and her manner of explaining them will tell you a lot.

Your questions about her experience should be extensive. Find out exactly what she has done in previous jobs. Get in touch with her former employers, even though she has letters of recommendation from them. (If she doesn't want her *present* employer to know that she is looking for another position, you will naturally not call him.)

Her reasons for wanting to leave her present position are important, too; they may indicate the kind of job she wants. If yours doesn't measure up to her requirements she won't be happy very long—and you'll soon be looking for another aide. So ask her to describe the kind of job she considers ideal. Her answer may tell you whether she is sensible or impractical.

In discussing salary, bear in mind that it may be wise to pay a little more than you had intended if a girl appears to have unusual capabilities. Perhaps you can offer the additional amount in the form of a raise after, say, two months.

A trial period, by the way, may be suggested if you feel that you must test secretarial or laboratory

Phillips' Milk of Magnesia

is generally accepted by the medical profession as a standard therapeutic agent, being so recognized for more than 70 years.

As a laxative—it is gentle, smooth-acting without embarrassing urgency.

As an antacid—affords effective relief. Contains no carbonates, hence no discomforting bloating.

DOSAGE:

Laxative: 2 to 4 tablespoonfuls

Antacid: 1 to 4 teaspoonfuls, or 1 to 4 tablets

Caution: Use only as directed.

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Liquid
4-oz. bottle
12-oz. bottle
1-pt. 10-oz. bottle

Tablets
box of 30's
bottle of 75's
bottle of 200's

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ability. Make it a two-way arrangement, with either party free to terminate the engagement without notice within, say, a thirty-day period.

If you feel that you can't insist on a trial period, do the next best thing: Request your applicant to come in for a second interview. Ask her to call you—personally—at a certain time to arrange the appointment. Then you will have the opportunity to judge her telephone voice and manner—an important factor where telephone conversations with patients are numerous.

If a girl has an exceptional personality but lacks some technical asset (*e.g.*, shorthand, a medical vocabulary, or knowledge of laboratory technique), she may be willing to take a course in the needed subject. It may even be to your advantage to finance such training.

Mention the various items of office equipment (*e.g.*, dictating machine, telephone switchboard) which your applicant will be expected to operate. Ask, too, if she can drive a car.

Aptitude testing is helpful if an applicant seems promising but is without medical experience. In the larger cities, firms and foundations specializing in psychological studies conduct such tests—usually at a fee ranging from $15 to $75. Names of such organizations may be found in the classified telephone directory (under "Psychology") or by inquiry at any university which maintains a psychology department. But be sure you engage a reputable one—there are racketeers in the business.

—MARVIN LEWIS

Use Caution in Certifying Insanity

State laws governing the commitment of persons to mental institutions are not uniform. However, certification of insanity by one or more physicians is commonly a prerequisite. Usually, an examination is required; and, while a physician may not be held liable for an error in judgment based on such an examination, any failure to conduct one when it is required is fraught with danger.

Law reports include frequent accounts of cases in which physicians have signed insanity commitments *pro forma*, and thereafter have been called to account. The following citation (24 So. 968) illustrates the danger to a doctor in omitting an examination when the law prescribes it:

The plaintiff had been committed to an asylum for treatment on a certificate of insanity signed by two physicians. The latter had made no specific examination [*Continued on next page*]

of the plaintiff to determine her sanity before signing the certificate. The plaintiff, after three months' confinement, was released by the institution, which certified she was not insane. Suit against the physicians for damages resulted in a judgment of $1,500, although they had contended that their certification was merely an expression of opinion. On appeal, a higher court affirmed the judgment in this language (condensed):

"All who unite in procurement of an illegal commitment are equally liable in an action for false imprisonment. In the case before us, both physicians did certify that they had examined the defendant and found her a fit subject for treatment in the asylum. In truth, as both physicians frankly testified, they had not examined her as to her sanity or insanity.

"It is true that both had observed the plaintiff in a casual way, and not professionally. One had observed her on a single occasion when she was awaiting the services of a shoe store attendant. He saw her gazing out into the street with a vacant stare.

"The other physician had greater opportunities for observation, with the result that he noticed her sad and silent, inattentive to what was transpiring around her, and, on one occasion, sitting with her hands folded on her lap, facing the wall, and refusing to be drawn into any conversation.

"But these were not the examinations required precedent to commitment. The jury has found that the plaintiff was not insane, and we cannot say that the jury was wrong. Affirmed." —LESLIE CHILDS, LL.B.

ANSWERS TO QUIZ, PAGE 125

1c. 2b. 3e. 4d. 5c. 6e. 7d. 8c. 9b.

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FOR EFFECTIVE *and* PROTECTIVE

Nasal Therapy

UNUSUAL "DRYNESS" of the nose — whether in the initial stage of a cold, or as a result of unfavorable climatic conditions, or secondarily following the instillation of aqueous solutions — may be considerably relieved by the intranasal administration of an oil spray[2] or drops like *Pineoleum*. So, too, may the irritation induced by many strong saline or ephedrine solutions—with their tendency toward "pickling" the delicate epithelial lining and depriving it of its normal protective covering.[1] • Indeed, *Pineoleum* is highly favored for symptomatic relief of the nasal manifestations of coryza because of the soothing and protective action inherent in its liquid petrolatum base and contained ingredients. It has also been observed that *Pineoleum* with Ephedrine (with its *moderate* ephedrine content) helps reduce inflammation and improve ventilation and drainage without fear of undesirable turgescence, atony and bogginess.

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PLAIN OR WITH EPHEDRINE

PROTECTS WHILE IT RELIEVES

References: 1. Goldsmith, P.G.: Canad. M. A. J., 48:426, 1943.
2. Spearman, M. P.: Texas St. J. Med., 39:390, 1943.

How to Assure Health Legislation That Will Benefit the People

A willingness to spend money—and lots of it—is the main requirement

The change in the situation facing the medical profession today has come about so rapidly and with such great force that we must all revise our thinking and our planning. We now find our profession attacked on a broad front by politicians under the leadership of the highest elected official of our country, the President. We now face the threat of the socialization of the medical profession—even though the President and his colleagues seek to steer away from that expression—under the strongest program so far advanced by the social planners of this or any other era.

The program being advanced by the President at this time is almost identical with the one proposed by our Governor of California last January. The objectives then were the same; the same cry was raised that it was not socialized medicine; the allies of our governmental head were the same. And, make no mistake about it, those allies are powerful. In California we found the AFL linked up with the Governor in his program. We found the CIO very much on that side, too, as were the Congress of Parent-Teachers Associations and the League of Women Voters. That was tough competition; but it was possible to overcome it, at least for the time being.

If we handle ourselves properly in 1946 we can do the same thing on a national scale that a handful of us were able to do in California last year. We have available to us the same tactics, the same techniques, the same opportunities.

Just what is behind the new Wagner-Murray-Dingell bill? Why has the President come out in favor of it? These questions should be uppermost in our minds because only by knowing why the other fellow is aiming his shots in our direction can we hope to defend ourselves against his attack.

We may as well admit among ourselves that there is an uneven distribution of medical care. Some states enjoy four, six, or ten times the amount of medical service that other states have. Some report six, eight, or ten times the hospital beds

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▶ Dr. Philip K. Gilman, the author, is president of the California Medical Association. This article approximates an address he delivered before the first annual Conference of Presidents and Other Officers of State Medical Societies on December 2, in Chicago.

when we were young and gay

"Childhood," to paraphrase G. B. Shaw, "is such a delightful period that it seems a shame to waste it on children." Yet, old age also may be delightful.

For those who remain young in heart, their spirit warmed by tender reminiscence, the advancing years pass gracefully. For others, these may be lean and bitter years of depression . . . the mind and body plagued by a host of minor ailments. Chronic constipation imposes a particularly oppressive burden.

Gentle yet effective management of constipation with 'AGAROL'* Emulsion brings welcome relief to those who were once young and gay; as well as to those who are still young . . . and should be gay.

For additional pharmaceutical details consult your pharmacist—for more extensive medical data write Medical Division.

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on a per capita basis that others have. Even within the boundaries of individual states, some counties are relatively surfeited with medical service while others are starved for it.

Among the various levels of our society, some groups, some income levels, enjoy adequate medical service while other groups suffer from a lack of it. We look around and see our splendid teaching institutions and our modern hospitals; while at the same time we observe people who cannot find ready access to these facilities because of the financial barrier raised between the patient on the one side and the doctor on the other.

In the face of these obvious facts we must recognize the problems of medical economics raised in proposals such as those the President has made.

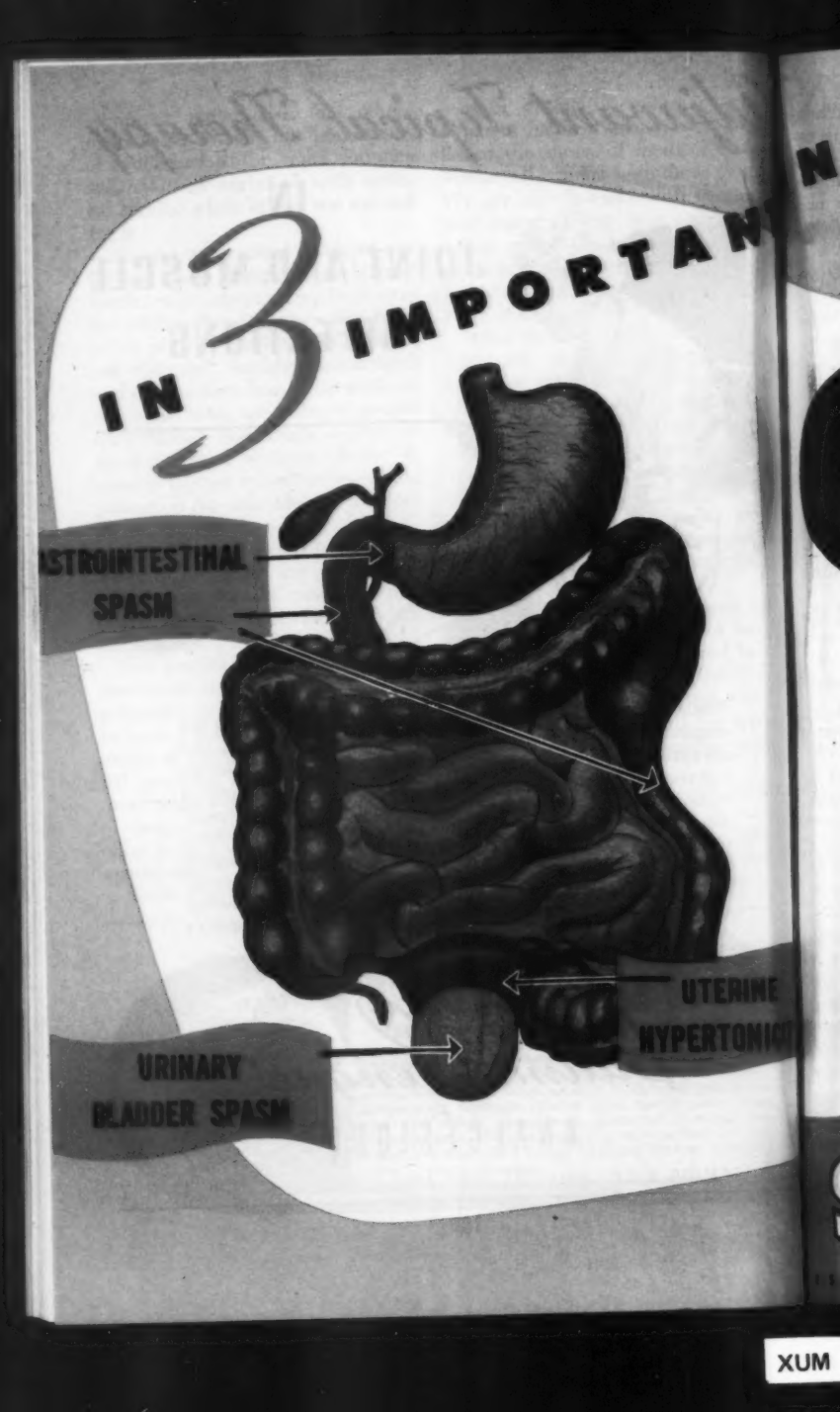
Our problem—and our only problem—is to see that these medical-economic questions are answered in such a manner that the best elements of medical science and medical practice are maintained. We must make certain that the *quality* of medical care does not suffer in an effort to increase the *quantity* or the *availability*.

Some of our states have taken the lead in setting up voluntary prepayment medical care plans which lessen the shock of medical costs. We are all familiar with these plans. We are also familiar with the fact that many of our own colleagues either refuse to accept such plans or enter into them in so grudging a fashion that they do the plans more harm than good.

After the President's statement to Congress, there is no longer any room for doubt about the necessity or wisdom of providing a prepayment system for meeting medical care costs. The only question concerning us today is one of method: Shall prepayment be provided by voluntary means under our own sponsorship or shall it be provided by compulsory means under a Government bureaucracy?

In the past year it has been my privilege to have available a large mass of information gathered by a special representative of the California Medical Association from sources in more than half our states as well as in several Canadian provinces.

From a study of this information it is clear that the success of medically-sponsored prepayment plans is in direct proportion to the willingness of the profession to as-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—provides Pavatrine, an antispasmodic which is unique in its *combined neurotropic and musculotropic spasmolytic* actions, augmented by the central nervous system sedation of phenobarbital. Pavatrine with Phenobarbital is non-narcotic—free of undesirable side effects.

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RESEARCH IN THE SERVICE OF MEDICINE

sume responsibility for them. Where physicians have shouldered this responsibility the prepayment plan have prospered and the public has been well served. Where the profession has ducked the responsibility completely—or has turned it over to the other fellow—these plans have had a mediocre growth at best.

It is paradoxical that medicine should be so willing to assume responsibility for the complete care of the indigent while so persistently dodging that responsibility as long as the patient still has a dollar or two. In my opinion, we as a profession must fulfill our duty to the entire population, regardless of income status. We must take care of the middle- and low-income groups just as readily as we treat the charity cases in our county hospitals.

In California we have faced the threat of state medicine almost constantly for the past seven years. We have met that threat by undertaking a prepayment plan which we hope will be extended to so many of our people that comparatively few will be left to demand state medicine. Had we in California been able to move faster and cover more people, we would not have had the really dangerous threat which faced us and caused us so much work last year.

If the same sort of voluntary program had been prevalent all over the country—if every state in the Union had been offering a medical care plan which the average wage-earner could afford to subscribe to on a payroll-deduction basis—we would today have so many people enrolled in the system that the plea of the President would fall on deaf ears. As it is, we have not sowed enough seed to cover the ground;

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KELEKET KXP-100
DIAGNOSTIC UNIT

YOU physicians who have longed for the convenience of X-ray equipment right in your own office will find everything desired in this KELEKET KXP-100 Diagnostic Unit!

It has sufficient power to take care of all radiographic and fluoroscopic requirements in the vertical, horizontal, and Trendelenburg positions. It is extremely easy to operate, because of the famous Multicron control with the KELEKET fixed milliamperage feature. A space only 8 x 10½ feet is adequate for the complete installation . . . and the total cost is surprisingly low!

Imagine how valuable this KELEKET Diagnostic Unit will be in your practice. You'll obtain brilliant films of fine diagnostic quality, even of the skull, abdomen and other heavy parts of the body. You'll be able to confirm your clinical diagnoses quickly, *right in your own office.*

America today is more "X-ray conscious" than ever before. Investigate this KELEKET KXP-100 Diagnostic Unit now. Ask the KELEKET representative in your city, or write us direct.

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Let MAZON end the search for a *satisfactory* Dermal Therapeutic

When skin conditions fail to respond satisfactorily, the tendency may be to switch from one medication to the other, with resulting delay and inconvenience to the patient.

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Clinical experience shows that many skin cases which failed to respond to the use of other medicaments, showed gratifying improvement with the Mazon treatment. Results with Mazon are often surprisingly rapid.

On its record of success, why not try Mazon? It may eliminate further experimentation and spare the patient needless irritation.

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Indications include Eczema, Psoriasis, Ringworm, Dandruff, Athlete's Foot and other skin irritations not caused by or associated with systemic or metabolic disease. Mazon is anti-pruritic, anti-septic, anti-parasitic, It is easy to apply and requires no bandaging.

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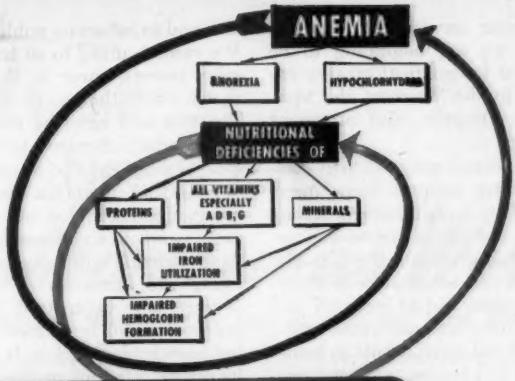

THE VICIOUS CYCLE OF *Nutritional Deficiency* IN HYPOCHROMIC ANEMIA

Patients with hypochromic anemia resulting from nutritional deficiencies or blood loss exhibit one common feature: With anemia once established, the ensuing reduction of gastric acidity, lack of appetite, and increased fatigability tend to decrease further the food intake, thus promoting or intensifying nutritional deficiencies and the progress of anemia.

Hence anemic patients will be benefited most if not merely iron is supplied (usually but one of the deficient nutrients), but also the factors which make for optimal iron utilization, which lessen fatigability and increase the appetite.

Heptuna provides not only an adequate amount of highly available iron but, in addition, notable quantities of the fat-soluble vitamins A and D, and the B-complex vitamins (partly derived from a vitamin-rich liver extract and yeast).

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Each Capsule Contains:

Ferrous Sulphate U.S.P.	4½ Grains
Vitamin A (Fish-Liver Oil)	5,000 U.S.P. Units
Vitamin D (Tuna-Liver Oil)	500 U.S.P. Units
Vitamin B_1 (Thiamine Hydrochloride)	2 mg.
Vitamin B_2 (Riboflavin)	2 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.1 mg.
Calcium Pantothenate	0.333 mg.
Niacinamide	10 mg.

Together with a Liver Concentrate (Vitamin fraction) derived from 6.5 Gm. fresh liver and dried yeast U.S.P. Not intended for use in the treatment of pernicious anemia.

Heptuna

a ROERIG *Preparation*

and without an adequate ground covering we are beginning to be threatened by political erosion engineered by the Wagners, the Murrays, the Dingells, and others of their kind.

Mr. Truman's proposal will command strong support from many sources. It is a composite program, including not only a system of compulsory sickness insurance but also a hospital and medical center construction plan, aid to research and medical education, and other items. Parts of it we must admit as beneficial and in keeping with our own traditions. Other parts we must reject.

Before rejecting any provisions, we should of course be ready with substitutes; for in politics it is axiomatic that you can't beat something with nothing. The passive resistance of Mahatma Ghandhi won't work if we are to preserve our freedom of enterprise.

It should be obvious that any legislation we may develop for introduction into Congress will be utterly lost unless we implement it with the proper sort of organization. It is one thing to get a bill introduced and another thing to get it adopted. Many of us have had experience in our own state legislative processes and we realize what it takes to get bills either passed or killed. Call it pressure politics, call it lobbying, or call it propaganda: The fact remains that certain steps must be taken to influence legislation and to influence public opinion. We cannot afford to sit back in our ivory towers, smug in the thought that we hold the key to the medical situation and ignoring the political forces which threaten to break the lock without the use of our key.

American medicine today must reorganize itself. Let me put those same words in another order: American medicine must reorganize itself *today*—not tomorrow or next year. It must take upon itself the job of urging helpful legislation and killing harmful legislation. It must face its public relations problem squarely and do something about it. It must enter the political scene actively and forcefully. And, I repeat, it must do this *today*.

In the last few years the need for this sort of reorganization has been brought home to us by several agencies which have sprung up on the edges of organized medicine. The National Physicians' Committee, the United Public Health League, and the Association of American Physicians and Surgeons, for instance, have all blossomed in fertile ground while our own medical organizations have in most instances sat by and watched. These groups were not generated in a vacuum. They have come to life and thrived because there is a demand for the type of service they perform.

In the last two years we have seen the AMA develop its Council on Medical Service and Public Re-

VIM is the Needle for *Intravenous Work*

and your favorite lengths and gauges are now available

Ask the surgical dealer's representative for the needle most favored for Intravenous work by thousands of physicians and specialists—the Square-Hub VIM.

Made from genuine Stainless *Cutlery* Steel, the VIM point is beautifully tapered and hollow-ground; the flat edges of the point are razor-sharp and thus gently slit tissue and vein wall instead of puncturing. Most important, VIM points hold their sharpness despite continued use and sterilization; they are heat-treated and uniformly tempered to exactly the hardness required to assure long-lasting service in a cutting instrument. If it's a VIM, it stays sharp longer.

For intravenous work, VIM Stainless *Cutlery* Steel needles are now available in the following lengths and gauges, all with Intravenous Points (18°):

25 Gauge, ¾"	21 Gauge, 1"
24 Gauge, ¾" ½"	20 Gauge, 1" 1½"
23 Gauge, ¾"	18 Gauge, 1½"
22 Gauge, ¾" 1" 1¼" 1½"	

Order these sizes from your surgical instrument dealer. Write us for a complete list of sizes for general Hypo use, for Intramuscular, Intradermal, Subcutaneous and Immunization work.

Hollow-Ground Points *Keen-Cutting Edges*

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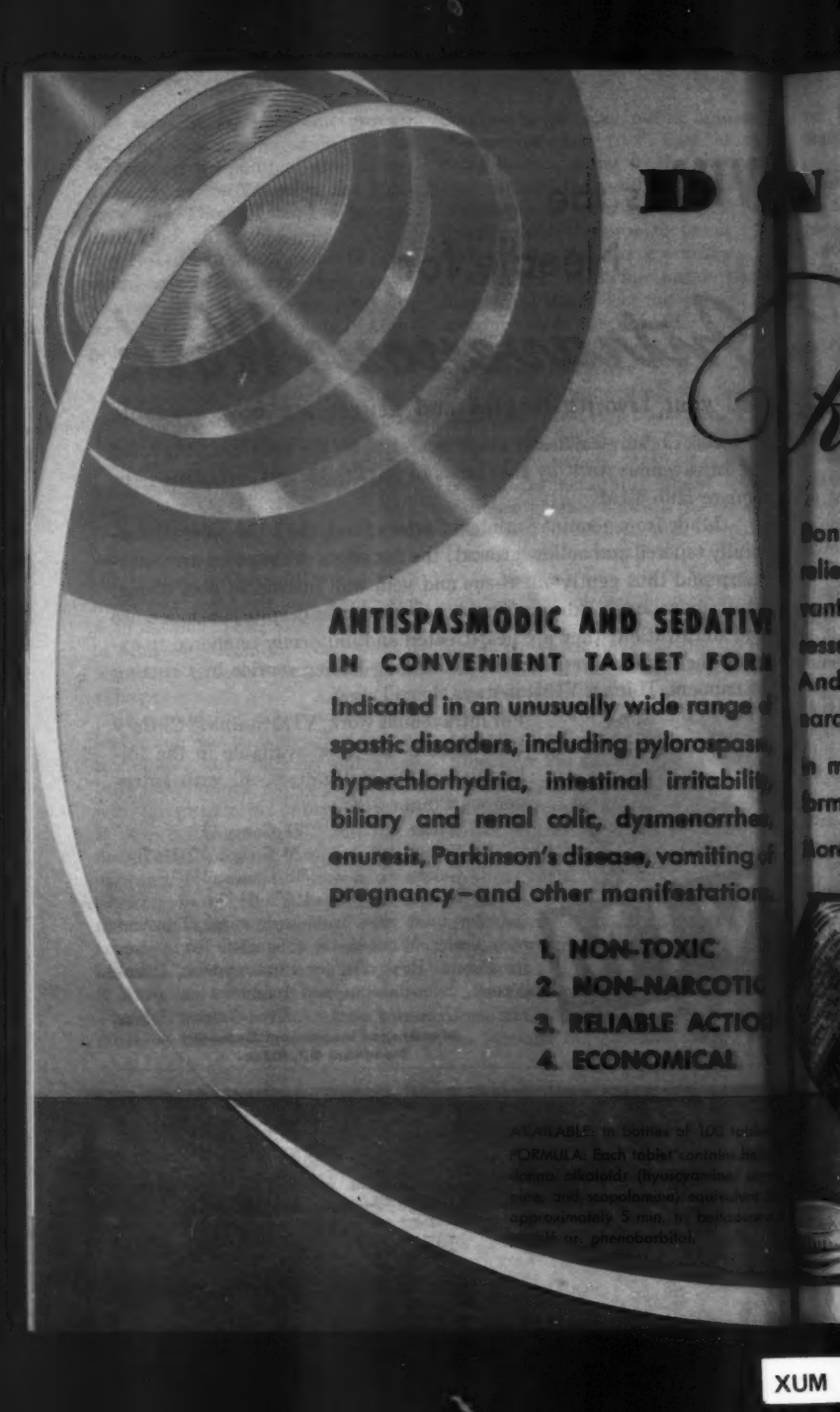
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DONNATAL

DEPENDABL[illegible] ANTI-SPASMODIC AND SEDATIVE

lations. And many of us have been bitterly disappointed that the council has been so bound up in red tape or in administrative difficulties that it has not yet served its real purpose. We have seen in the formation of the council a compromise between the aggressive and the staid elements of our profession—a compromise which has resulted in a half-way project which at best can take no more than half-way measures. *Today half-way measures are not enough.*

Don't misunderstand me. I am not blindly criticizing the council. I want to see it become the official voice of organized medicine in both the legislative and public relations fields. I advocate its expansion to a point where it can take over the activities of the NPC, the UPHL, the AAPS, and other organizations which today are in existence because they are needed.

The council should be able to give form to the legislation which we hope to draft from our collective thinking. I recommend furnishing it with everything it needs in order to function properly—that is, men, money, prestige, and authority. We can afford the money. We can lend our own support to give it prestige. And we can confer the necessary authority, properly controlled by ourselves, to carry out the program we assign.

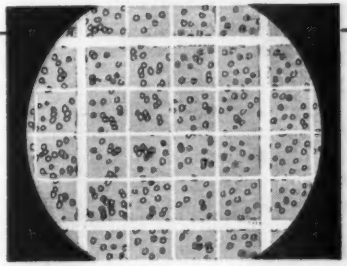
As to the men required, I would say this: First, select them not on the basis of the degrees they possess but on the basis of what they know, whom they know, and what they can accomplish. We need men who can do what has to be done, and we must pay them whatever is necessary. No salary is too high.

Second, pick young men. Not college sophomores, but young men of brains and judgment with the flexibility and vigor of youth. Too often our medical organizations are operated by men so mature that they lack the punch needed in the pinches. I have been urged in my own state to continue in the administrative end of our state medical association, but I am too far advanced in years to carry on the active work we need. There are plenty of younger men in the offing who can deliver a harder blow when it is needed. The very physical beating that some of our men took for six months last year in fighting state medicine in California convinces me that age must be recognized as a barrier if we are to win the larger fight scheduled in Washington.

—PHILIP K. GILMAN, M.D.

Number 3 of a Series

IN ANEMIA OF CHRONIC BLOOD LOSS



In the management of chronic blood loss, therapy designed to support red cell and hemoglobin formation is essential. Iron must be supplied to correct hypochromia; liver and the B vitamins bolster an overworked bone marrow in the production of red cells. The combination is more effective than iron alone.

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Bottles of one pint and one gallon. Tasting samples on request.

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If a Surgical or Hypodermic Needle Breaks, What Is Your Liability?

An attorney supplies the answer, plus some precautions to observe

The breaking of a surgical or hypodermic needle is not, *per se*, evidence of negligence. It is for the patient to prove that the physician or surgeon was careless and that such carelessness was the proximate cause of the injury. For example:

A small boy stepped on a broken glass jar, cutting an artery in his foot. Repair was difficult because the bones were so close together. As a result, two surgical needles were broken in the wound. The surgeon attempted to locate the pieces with his gloved finger, but failed. He felt it would be unwise to probe further then and risk spreading the infection already present. The needles worked eventually to the surface of the child's foot and were extracted by his mother. Evidence established that the needles had been sterilized and that such needles do not cause infection even though they are broken off and remain in the wound. It was also shown that sterile needles remaining in an infected wound eventually work out, while those remaining in an uninfected wound may work out or may become encisted. The court dismissed the complaint for lack of proof of negligence.

▶ Emanuel Hayt, the author, is a member of the New York Bar and of the Society for Medical Jurisprudence. He is also an associate member of the American Hospital Association. While specializing for the last fifteen years in medical and hospital law, he has written several books and numerous articles for medical and hospital journals.

ADVISING THE PATIENT

When such an accident occurs, the surgeon need not immediately notify the patient of the broken needle or attempt to remove it at once. On the other hand, neither he nor the anesthetist may keep permanently silent and do nothing about the matter.

In one case a patient engaged a surgeon to operate on her for a kidney condition. The surgeon employed another physician to act as anesthetist. While a spinal anesthetic was being administered, a piece of the needle about one inch long broke off. The anesthetist notified the surgeon, who decided to leave the particle in the patient's spine for the time being. By another operation ten days later, the broken needle was removed. The patient sued the anesthetist for negligence in administering the anesthetic, for permitting the needle remnant to

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remain in her spine, and for not informing her of it until the day it was removed. The anesthetist proved by expert witnesses that an anesthetic needle could break even though used with care. He demonstrated that he had immediately informed the patient's physician of the breaking and that her physician had decided to let the needle remain in until later. He testified also that he had used standard methods in administering the anesthetic. Upon this proof the court directed a verdict for the anesthetist and dismissed the complaint.

In another case it was held that the jury would be justified in finding a physician guilty of malpractice where nothing was said to the patient after a fruitless probing and the needle was removed later by another physician. In that case the testimony indicated that while a surgeon was suturing a rectal incision, one of his assistants snapped the anesthetic needle. After unsuccessful probing, the operation was completed and the particle was left in the rectal wall. For almost two years the patient, who knew nothing of the broken needle, visited the surgeon's office, complaining of pains. No relief was afforded, so he finally consulted another physician who removed the particle. After that the patient had no pains.

From the proof offered the court, it appeared that in such a case the surgeon might properly leave the needle in the body and await later manifestations, rather than subject the patient to the danger of further cutting under an anesthetic. However, the court felt that such a policy of waiting in silence and doing nothing should be purely temporary and that to continue it indefinitely, as in the case at hand, constituted actionable negligence.

Another pertinent case concerned the breaking of an anesthetic needle incident to a tonsillectomy. The doctor believed it proper not to inform the patient until she had had a fair opportunity to rest and sleep. Later in the day, therefore, she was advised of the accident. Immediate arrangements were made to locate the particle by X-ray and to have it removed by a well-known surgeon. Although the needle was properly extracted, and at the attending physician's own expense, the patient instituted a malpractice suit. At the trial, the court stated that malpractice was not shown by the fact that the needle broke, or that part of it remained in the patient's body. The fact that the needle was not immedi-

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ately extracted did not constitute negligence, for the physician had made every effort to locate and remove it. He was deemed to have acted reasonably in proceeding with the tonsillectomy without first notifying the patient about the broken needle, for it was his hope to discover and extract the piece later. The court therefore held in favor of the physician.

FAILURE TO X-RAY

Failure to X-ray promptly for a broken needle may be malpractice, and continuing to probe for such a needle when probing threatens to push the needle in farther may also be malpractice.

In one case a surgeon's assistant broke a hypodermic needle in the tonsillar area. The needle remained there despite several operations to remove it. The surgeon in question was a nose and throat specialist and had practiced for twenty-one years. A medical expert, called in behalf of the patient, testified in court that it had not been good practice under the circumstances to proceed with the tonsillectomy. Nor was it good practice, he said, to attempt to take out a broken needle without first X-raying for it or to let a patient go home and be without medical attention for almost two weeks after the breaking of a needle. The testimony was not merely to the effect that the expert witness would have done the work differently, but rather that the methods adopted were not consonant with approved practice. The jury awarded a verdict in favor of the patient and the judgment was sustained on appeal.

STANDARD OF SKILL

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ministration of anesthetics, and in the performance of lumbar punctures or other subcutaneous procedures, the physician is required to exercise that degree of skill and learning used under similar circumstances by members of his profession in good standing. He must also use reasonable care, diligence, and judgment. An additional requirement when a surgical procedure is performed is that the operation be done according to accepted standards.

While treating a patient for pleurisy with effusion, a physician attempted a chest tap. He inserted an 18-gauge hypodermic needle posteriorly between the seventh and eighth ribs and succeeded in drawing off 1½ c.c. of fluid from between the pleura and the lungs, when, due to a sudden movement of the patient, the end of the needle broke off inside the thoracic cavity. X-ray examination showed the fragment lodged in such a position that its removal was inadvisable, if not impossible. The patient recovered from the pleurisy, but the needle fragment in his chest caused him considerable pain and some disability. The patient's case against the physician was based on alleged admissions of fault made by the doctor immediately after the accident, on his failure to guard against movement of the patient during the operation, and on his having attempted an operation which he allegedly knew he was incompetent to perform. The complaint was dismissed, however, since expert testimony showed that the operation had been conducted according to accepted professional standards.

EXPERT TESTIMONY

Malpractice may be proved ordinarily only by the testimony of those skilled in the particular field in which the malpractice is charged.

A case in which this rule was applied involved the breaking of a drill during a bone graft. (There would be no difference legally whether the instrument broken was a needle or a drill.) The patient in question suffered a transverse fracture of the humerus of his right arm. A surgeon performed an open reduction. The surgeon kept in touch with the patient and some weeks later told him there was not enough callous formation to effect a union. Another operation was advised with a bone graft to be taken from the patient's right tibia. To attach the tibial graft securely to the severed parts of the broken humerus, the surgeon planned to use four ivory screws. Holes for three of the screws were bored without difficulty, but in boring the fourth hole the steel drill broke. A 1½" portion of the drill, which extended through the graft bone and into the humerus, was allowed to remain. The physician decided to let it serve in lieu of the fourth ivory screw. Following the operation a sinus developed from which pus exuded. Another operation was then suggested, but

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THERAPEUTIC APPRAISAL: Only slightly ionized, therefore virtually non-irritating even when administered before meals. Soluble throughout entire pH range of gastro-intestinal tract. More efficiently utilized than other iron salts.*

*J. Clin. Investigation 16:547, 1937.

INDICATED in treatment and prevention of hypochromic anemias, especially in patients intolerant to other iron salts.

DOSAGE: Adults, 3 to 6 tablets (5 gr.) or 4 to 8 teaspoonfuls elixir daily. Children, 1 to 4 tablets (2½ gr.) or 1 to 4 teaspoonfuls elixir daily.

SUPPLIED as 5% elixir, bottles of 6 and 16 fl. oz.; 2½ gr. tablets, bottles of 100; 5 gr. tablets, bottles of 100, 500 and 1000.

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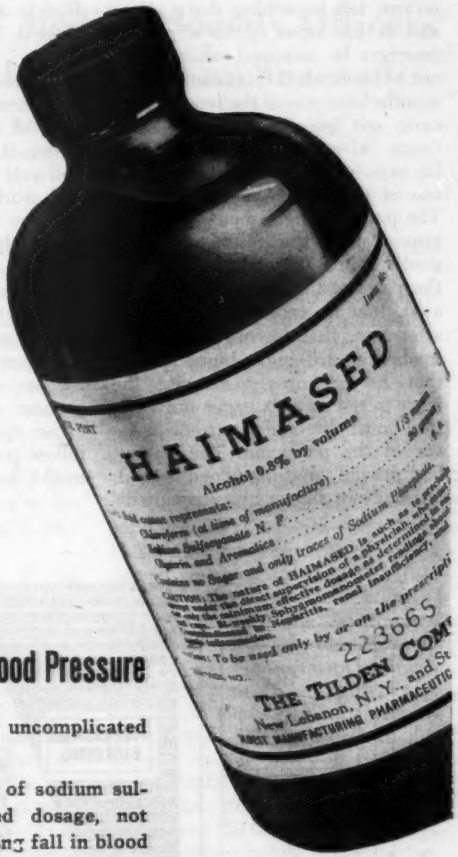

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the patient declined. Six months after the drill had been broken, the patient felt something sharp at the site of the sinus. With a pair of tweezers he removed what turned out to be the drill fragment. Several months later one of the ivory screws came out from the site of the incision. After that the condition of his arm improved. But full normal use of the limb was not restored. The patient sought damages on the ground that the physician negligently failed to secure a union of the parts at the time he first operated, that he rendered inadequate after-care, that he negligently left the broken drill in the humerus, and that he improperly inserted the ivory screw which came out. The trial court directed a verdict in favor of the physician. The patient had proved what happened, it said, but had not shown by expert medical testimony that the method of treatment followed was improper. Had he attempted to do so and succeeded, he would have won.

CONCLUSION

While the breaking of a needle i not *prima facie* negligence on th part of the physician, he cannc ignore the presence of the partick and rely on the possibility that i will work its way out. It may b that the patient cannot be told immediately about the broken needle, nor may it be advisable to attempt to remove it at once. But action must be taken at the right time.

The physician should X-ray, if necessary, to determine the proper location of the fragment and then proceed according to such methods as are approved practice among his fellow practitioners; a consultation might be a good safeguard.

—EMANUEL HAYT, LL.B.

Altmeyer Tells Medical Society Officers Only Federal Program Can Succeed

Head of Social Security Board says compulsory insurance would help, not hinder, doctor

If organized medicine is willing to step in and help formulate a Government program of compulsory sickness insurance it can eliminate, from the beginning, any threat of regimentation or political dictation, declared Arthur J. Altmeyer, chairman of the Social Security Board, in an address before the Conference of Presidents and Other Officers of State Medical Societies, held last month in Chicago, just prior to the meeting of the AMA House of Delegates.

Denying that the U.S. is the healthiest country in the world, Mr. Altmeyer quoted statistics of the years just prior to the war. "Perhaps the best single measure of our relative health status is the infant mortality rate. In terms of this index we stood seventh [among nations]. Moreover, the comparisons in general were increasingly unfavorable to us as we proceeded from the death rates for infants to those of older groups of our population."

More to the point, Mr. Altmeyer added, would be a comparison of morbidity and mortality rates by sections of the U.S. He gave several examples:

¶ Some states go through a year without a single reported death from diphtheria; others have as many annually as 4 per 100,000 population.

¶ In a number of states, deaths from tuberculosis are only one-fifth or one-sixth of those in the state with the highest rate.

¶ In 1943, the state with the lowest infant mortality had a rate only one-third that of the state with the highest.

Continued Mr. Altmeyer:

"It is still commonly said that the poor and the rich get the best care. This oft-repeated generalization has caused much confusion. The fact is that poor people have more illness and have higher death rates than the well-to-do, but they receive far less medical care per family and per case of sickness. Poverty, illness, and inadequate medical care go together. The National Health Survey, conducted by the United States Public Health Service in the winter of 1935-36, showed that there were 2½ times as many days of disability among persons on relief as among those having a family income of $3,000 or more. The number of days lost by persons not on relief but with a family income of less than $1,000 was twice that experienced by those with a family income of $3,000 or more.

"This survey also showed that while there was much more serious

disability among those with the least income, a substantially larger proportion among them than among those in the higher income brackets failed to receive any medical attention whatsoever.

"The survey also showed that disabled persons in the low-income brackets who did receive medical assistance had had fewer visits from physicians than disabled persons in the higher income brackets. Summing up the results of various surveys, it appears that the amount of medical care received by persons in the low-income brackets has been about one-third as adequate in amount as the care received by those in the upper-income brackets.

"The reason for this difference should be obvious. Medical care costs money and the poor have less money to pay for it. Various public opinion polls show that from 30 to over 40 per cent of the American people have put off going to a doctor because of the cost. Individual doctors are not to be blamed for this. Financial barriers—not doctors—are the cause of the inadequate care which our people receive.

"If we agree that nobody should suffer or die for lack of access to medical care, do we not have an obligation to break down the financial barrier between sick people and their doctors and hospitals? Is a democratic government meeting its full responsibility if the primary essential of human existence—the health of the people—is not safeguarded and improved to the utmost extent that medical science and our resources make possible?

"The so-called 'medically indigent' is a statistical term to describe classes of persons rather than individuals. Whether a given individual falls within the classification of medically indigent depends not only on his income but also on the amount of sickness that he happens to have. Dr. Leland, director of the Bureau of Medical Economics of the American Medical Association, presented data in 1939 in which he showed that people with an income of less than $3,000 a year may be medically indigent under certain circumstances—depending upon the type of illness they suffer.

"In 1935-6, over 92 per cent of the people in this country were in families that had an income of less than $3,000. Even with the increase in per capita income since that time, the majority of people in this country still have an income of less than $3,000, which of course purchases far less today than it did ten years ago. Therefore, the fact remains that only a fraction of our people can pay for all needed medical services for serious illnesses.

"The only way most of the American people can meet this problem is by spreading the cost of medical care over sufficiently long periods of time and among large enough groups of persons so that the cost will not be unbearable in the individual case. Some people have sug-

gested that it should be sufficient to spread only the cost of so-called catastrophic illnesses. One disadvantage of that approach is that people of low or medium incomes would still have to bear a considerable cost. Another disadvantage is that if they had to pay, for example, the first $50 of the cost, they would still be deterred from consulting their physicians early in the course of a disease or for an apparently minor illness which later proved to be serious. Thus, the great advantages of early diagnosis and early treatment would be lost.

"If the problem is to spread the cost of medical care, the question remains why can't we rely on the individual to obtain his own insurance? Hard facts spell the answer. The poor cannot afford to pay the full insurance premium. Most of those who are normally self-supporting have immediate wants which press on them to the exclusion of protection against future possible costs that may not actually occur. In other words, our day-to-day wants and necessities induce us to take a chance.

"There are two possible ways in which the Government can undertake to spread the costs of medical care. One is through providing medical care free of charge to the recipient, financing it through general taxation. The other way is through a system of health insurance, financed largely through contributions by potential beneficiaries and their employers. Under the first approach, medical care would be provided just as education is now provided. The practitioners would probably be for the most part salaried officials employed by the agency of government providing the

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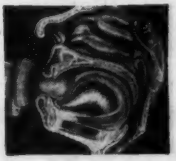

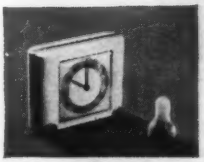

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medical services. Such a system is usually termed 'state medicine' and sometimes 'socialized medicine.' However, these terms are so indefinite and confused that they are sometimes used to cover not only public sanitation, public health services, and medical services provided by government for specific groups in the population, but also for health insurance.

"It is essential for clear thinking that the distinction between state medicine and health insurance be kept in mind. State medicine implies medical service provided by physicians employed by the government; health insurance, on the other hand, implies a system whereby medical service is provided by private, competitive practitioners who are reimbursed from a special insurance fund for the services they render. In other words, state medicine is not only a system for spreading the cost of medical care but also a system of medical practice; in contrast, health insurance is a system for spreading the cost of medical care and does not replace the competitive private practice of medicine.

"Many people sincerely believe that there is no essential difference between state medicine and health insurance. Perhaps outlining the elements of a system of health insurance will help to clarify the distinction.

"If Congress enacted a wholly Federal health insurance law, it would still be possible to allow for state administration. Contributions to finance the health services could be collected along with the contributions made under the Federal

old-age and survivors insurance system without any additional inconvenience to employes or employers, and without additional cost to the Government. The added cost of administering health insurance as part of a unified social insurance system probably would not exceed 5 per cent of the total cost of benefits provided.

"The administration of the benefits should be decentralized so that all necessary arrangements with doctors and hospitals and public health authorities could be subject to adjustment on a local basis. The local hospitals and doctors should be permitted to choose the method of remuneration which they desire. The method of remunerating hospitals could be on a fixed per diem basis regardless of the cost of the service to the hospital or the patient, or it could be on the basis of the actual cost of the service to the hospital—within fixed minimum and maximum limits—or it could be a combination of the two methods. The payment of doctors could be on the basis of fee for services, capitation, or straight salary—part-time or full-time—or it could be some combination of these arrangements.

"Besides free choice of method of remuneration, the system should provide, of course, free choice of physicians and free choice of patients. The professional organizations themselves should be relied upon to assist in the maintenance and promotion of desirable professional standards.

"Both individual and group practice should be permitted. It would be hazardous for a layman to undertake to discuss with physicians

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Swartz & Reilly, "Diagnosis and Treatment of Skin Diseases", p. 66

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the pros and cons of individual practice versus group practice. May I merely suggest that the development of adequate health facilities throughout this country—including hospitals, clinics, health centers, and diagnostic facilities, available to all of the physicians in a community—ought to help us to achieve the maximum advantages of both individual and group medicine.

"Many of the state medical societies have worked hard to set up systems of prepayment of medical care. They have encountered great difficulties, with which you are as familiar as I. Several of these plans, however, have met with considerable success. But whether or not they have met with success, these plans represent an earnest attempt on the part of organized medical groups to spread the cost of medical care while maintaining the professional relations desired by those groups.

"They have experienced one great difficulty that a general system of social insurance would overcome—the hazard of adverse selection. Any prepayment plan covering persons who can enter it and leave it at will is subject to this handicap. Under a general social insurance system, however, the problem of adverse selection is solved automatically, since the good risks as well as the bad risks are included.

"Under a system of health insurance, the Government could make arrangements to deal with the voluntary groups that furnish health services directly or pay for services rendered. The simplest arrangement would be for the Government to reimburse the organization either on an individual patient or service basis, or on an estimated total cost

you'll find Pentaplex especially valuable . . .

1. When dietary intake is inadequate due to anorexia, fatigue, nervous instability, faulty eating habits, dieting, etc.
2. When gastro-intestinal function is impaired by vomiting, diarrhea, constipation, or faulty absorption.
3. When B Complex requirements are increased (e.g., in growing children, during pregnancy and lactation, and in the aged).
4. In hyperthyroidism, infectious diseases, febrile conditions and convalescence.

Eskay's Pentaplex makes B Complex therapy palatable

An elixir compounded from five important factors of the Vitamin B Complex *in their crystalline forms.* Smith, Kline & French Laboratories, Philadelphia, Pa.

basis, having regard for the number of insured persons that it serves. Such a relationship would involve a minimum of control by the Government and a maximum degree of independence on the part of the group and the members composing the group.

"Any such plans would be as free as they are today to select their own staffs and their own method of paying doctors and others on their staffs.

"Under *any* method of payment, the rate of payment and the amount of payment to doctors should be adequate. This means adequate payments for general practitioner services and adequate payments for specialist services. The medical profession has a right to insist that the financial resources of a health insurance system shall be sufficient to pay adequately for high-grade services. Since the public would receive a larger amount of service with health insurance than without it, physicians as a whole would have a right to expect higher average incomes than they ordinarily receive.

"By and large, it seems to me that quality of care should improve rather than decline if payment for service is guaranteed. It is alleged, however, that other characteristics of an insurance system will dominate the picture. And one hears about 'regimentation' of doctors, 'assignment of patient,' 'political control,' etc.

"We are agreed, I believe, that the patient shall have free choice of doctor, and that the doctor shall be free to accept or reject patients. If the fee no longer stands between patient and doctor, the competitive relation between doctors will still remain, but it will rest on quality

NEW

...A more complete prophylaxis and treatment for secondary anemias

THERAPY of nutritional anemias with iron, iron and copper, liver concentrates, and Vitamin B Complex, has been advocated for many years.

All these agents now are combined in *FER-DONA* I.V.C.—*new product of choice in the prophylaxis and treatment of hypochromic and secondary anemias.*

FER-DONA employs *whole liver* substance fortified with a liver concentrate of blood-forming *Vitamin B Complex* factors.

FER-DONA contains bivalent *iron* —claimed to be clinically more effective than other forms of iron. *Copper*, too, is inherently present in FER-DONA.

FER-DONA contains pepsin which contributes to its easy digestibility. Vanillin and coumarin guarantee a pleasant flavor and odor.

A product of the International Vitamin Corporation, "The House of Vitamins," 22 East 40th Street, New York 16, New York.

The suggested daily dose of six (6) Fer-Dona capsules provides Vitamin B Complex Factors B_1 (Thiamine), B_2 (G) (Riboflavin), and PP (Niacin Amide) in the quantities recommended by the National Research Council, as well as liver fortified in hematopoietic B-Vitamins and iron.

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REG. U. S. PAT. OFF

I. V. C. Capsules with Vitamin B Complex for Secondary Anemias

These are the patients...

— neither seriously ill,
nor yet entirely well —
who often respond dramatically
to the administration
of a good tonic.

ESKAY'S NEURO PHOSPHATES
and
ESKAY'S THERANATES
— palatable,
easily tolerated
tonic preparations —
help restore appetite,
vigor
and general tone.

The overworked

The convalescent

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ESKAY'S NEURO PHOSPHATES

CLINICALLY TESTED AND CLINICALLY PROVED

The neurasthenic

The aged

The constitutionally delicate

The chronically fatigued

ESKAY'S THERANATES

THE FORMULA OF ESKAY'S NEURO PHOSPHATES, PLUS VITAMIN B1

and adequacy of care. These are essentials for continuing good care. Where then are the issues?

"One question concerns control over the professional aspects of medical practice. This is an ancient question—older than the Hippocratic Oath. The guidance, the direction, the supervision, the discipline of doctors are primarily matters for doctors to handle. Subject to Government regulation through licensure, the responsibility has always been yours and should remain yours. No Government officer in his senses would take any other position. Just as public licensure gave the profession a new opportunity to deal with these problems, just as grading of medical schools, registration of hospitals, administration of workmen's compensation, and establishment of voluntary insurance plans—to mention only a few—gave you new opportunities to exercise professional controls, so inauguration of health insurance gives you still another in the long evolutionary movement for high ethical and qualitative standards. On this broad question, health insurance presents not a major threat but a new, great opportunity.

"Another question is summarized in the phrases about 'regimentation,' 'a czar over medicine,' etc. There is one sure way for the medical profession to see that what it doesn't want doesn't happen, even by inadvertence; that is to participate in planning the program. If you do, I am sure you will find you are working side by side with friends of the profession. There is no problem here that can't be solved by men of good will."

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RIASOL "*works.*"

Proof of this is visible to the eye, beyond question or dispute.

Such obvious evidence outweighs all theoretical discussions and leads without further delay to but one conclusion—

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RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply RIASOL daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages needed. After one week, adjust to the patient's progress. RIASOL may be applied to any area, including face and scalp.

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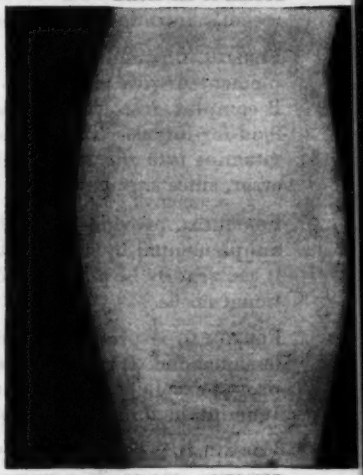

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Please send me professional literature and generous clinical package of RIASOL.

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FORMULAC . . .

an advance in infant nutrition

FORMULAC is the trade name for a new, vitamin-fortified infant food, developed by E. V. McCollum, and recently introduced on the market.

FORMULAC (a reduced milk in liquid form) is sufficiently supplemented with vitamins C and D, as well as vitamins of the B complex, iron, copper and niacin, to render it an adequate food for infants. The McCollum method of incorporating the vitamins *into the milk itself* eliminates the risk of maternal error, since supplementary administration is unnecessary.

FORMULAC provides a flexible basis for formula preparation. Supplemented by carbohydrates at the physician's discretion, it can readily be adjusted to meet the individual child's nutritional needs.

FORMULAC is promoted ethically — through the medical profession alone. It has been tested under clinical supervision, and proved excellent in promoting infant growth and development. It maintained its vitamin potency on storage.

FORMULAC is inexpensive—within the price range of even low income groups. It represents a *most reasonable cost* for a formula so nutritionally complete. It is on sale at most drug and grocery stores.

For further information about FORMULAC, and for professional samples, drop a card to National Dairy Products Company, Inc., 230 Park Avenue, New York 17, N. Y.

NATIONAL DAIRY PRODUCTS COMPANY, INC.
NEW YORK, N. Y.

NATIONAL DAIRY Sealtest PRODUCTS CORP.

In his report to the Council . . . on the local use of sulfonamide compounds in dermatology, Cole gives the formula of only one sulfonamide ointment, PRAGMASUL, and states that its type of base is apparently best. (J.A.M.A. 123:411-417, Oct. 16, 1943)

In Pragmasul's special oil-in-water emulsion base, the particles of sulfathiazole are not imprisoned in grease or oil, but are suspended in a continuous aqueous medium. Thus they pass freely into the aqueous serous exudate, ensuring intimate and prolonged contact with infected tissue.

In addition, Pragmasul contains Micraform (microcrystalline) sulfathiazole—approximately 1/1000 the mass of ordinary crystals. As a result, Pragmasul offers:

1 . . . enhanced therapeutic effect.
2 . . . lessened possibility of irritation.
3 . . . exceptional smoothness.

To prevent your prescriptions being filled with an inferior sulfathiazole ointment . . .

it is important to specify **PRAGMASUL**

on your prescriptions for 5% sulfathiazole ointment

Smith, Kline & French Laboratories Philadelphia, Pa.

The Newsvane

RECONVERSION of the wartime 9-9-9 program of interneships and residencies to a normal twelve-month service will mean, says the Procurement and Assignment Service, that hospitals "will be almost entirely dependent on nonmilitary personnel to fill residencies." Each must prepare to release, not later than April 1, every commissioned resident who has not seen military service and replace such men with veterans, who are becoming increasingly available.

The reconversion will be effected under the following plan:*

¶ Each commissioned interne completing his nine month's service on April 1 will continue in it until July 1. (But hospitals which cannot accommodate overlapping groups of internes for the three month period will release the April 1 group for military service on that date; also hospitals which find services of April 1 internes absolutely essential may apply to the PAS for their deferment.)

¶ Each commissioned junior resident whose residency terminates on April 1 will be called to active duty on that date if he has not already been released. (A request for deferral in rare cases will be entertained by the PAS.)

¶ Each commissioned senior resident who is completing his twenty-seven months of service in a hospital will be called to active duty on or about April 1, if not replaced by a veteran prior to that date.

¶ Senior students who will be graduated on or about April 1 are to be accepted for interneship on that date; they will be permitted to serve until July 1, 1947.

*The plan applies to the April group; information on others will be released later.

EMIC. The Children's Bureau reports that medical care under the Emergency Maternity and Infant Care program has been provided so far for 250,000 pregnant wives of service men and for 650,000 of their children. Costs of medical, hospital, and nursing care, the bureau says, average $100 a pregnancy, although as much as $1,000 has been spent on some individual cases. Cost of care for a sick infant averages $65.

HOSPITAL BOGEY. While doctors have been fighting the establishment of state medicine, a far greater and insidious menace has arisen in hospital domination of medical practice, Dr. Wilmot Read recently told the Spokane County Medical Society. Said he: "We are now approaching the day when physicians will be merely a class of skilled laborers, readily hired and fired by the community health center."

In substantiation, Dr. Read quoted the American Hospital Association as saying that "Diagnosis, treatment, and care of the ambulatory sick becomes increasingly the

function of the hospital as the hospital develops into the center of community health activities. The patient, whatever his economic status, is entitled to receive the service of the clinician, the surgeon, the pathologist, the radiologist, the nurse, and the lay people who attend him. All the services are part of the hospital."

HEALTH AGENCIES. "The voluntary health agencies of the country are at the crossroads. They have grown rapidly in number, in public esteem, and in resources. They must now give increasing thought to their effectiveness. The time has come when they must reorganize for the tasks that lie ahead. From now on, a more critical public will demand that its funds be used more wisely and economically, that the efforts be directed by skilled hands, and that there be team play among all voluntary societies and official agencies. The challenge must be met."

Thus writes Louis I. Dublin in his foreword to "Voluntary Health Agencies: An Interpretive Study," prepared by Selskar M. Gunn and Philip S. Platt under the auspices of the National Health Council and the Rockefeller Foundation (New York: the Ronald Press Company, $3).

How to meet such a challenge? The authors of the report offer no easy solution. They evidently regard unification of all voluntary agencies (*e.g.*, The National Tuberculosis Association, the National Foundation for Infantile Paralysis, the American Cancer Society) as an idéal that is not now practicable. Reason: The national agencies in the "big money" class are not likely to surrender their position so as to aid others which have been receiving meager financial support from the public.

The National Health Council itself is criticized. Says the report: "The council has not developed leadership in important cooperative health planning that called for action; it has not brought about joint financing of national health agencies; nor has it brought the several agencies or movements nearer unification. It has seldom spoken with the voice of authority on health matters, nor has it been—except in the early days—an effective agent in developing the health council idea on the local level."

What many communities need and are ready for, says the report, is

WHY THIS ENRICHED OATMEAL* FOR BABIES IS A GOOD STARTING CEREAL

Because it is very low in crude fibre and mixes to a fine consistency, Gerber's Strained Oatmeal is a good starting cereal for infants.

Its other qualities, pleasant taste, uniform texture and high-nutritional values make Gerber's Strained Oatmeal a highly suitable cereal all through babyhood. As the table below shows it is rich in added iron and thiamine (derived from natural sources).

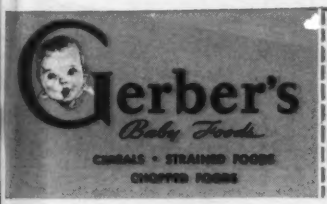
Pre-cooked, dried and flaked, Gerber's Strained Oatmeal is ready-to-serve with the addition of milk or formula.

Many physicians have found that serving Gerber's Strained Oatmeal, alternating with Gerber's Cereal Food helps baby eat better by avoiding monotony. Gerber's Strained Oatmeal is especially useful in cases where a wheat allergy is indicated.

*IRON AND THIAMINE VALUES OF GERBER'S STRAINED OATMEAL

	Thiamine mg.	Iron mg.
National Research Council recommended allowance for infants	0.40	6.0
One ounce Gerber's Strained Oatmeal	0.42	12.3

(Gerber's Strained Oatmeal: 109 Calories per ounce.)



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Gentlemen: Kindly send a complimentary sample of Gerber's Strained Oatmeal and a Professional Reference Card to the following address:

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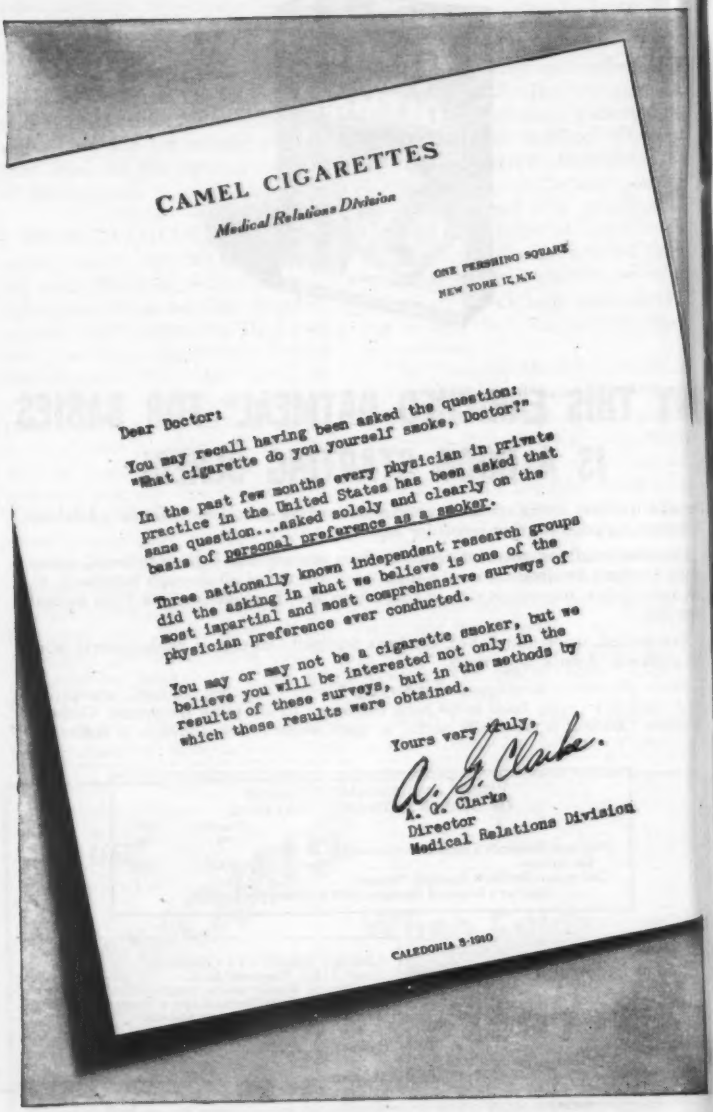

CAMEL CIGARETTES

Medical Relations Division

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NEW YORK 17, N.Y.

Dear Doctor:

You may recall having been asked the question:
"What cigarette do you yourself smoke, Doctor?"

In the past few months every physician in private practice in the United States has been asked that same question...asked solely and clearly on the basis of personal preference as a smoker.

Three nationally known independent research groups did the asking in what we believe is one of the most impartial and most comprehensive surveys of physician preference ever conducted.

You may or may not be a cigarette smoker, but we believe you will be interested not only in the results of these surveys, but in the methods by which these results were obtained.

Yours very truly,

A. G. Clarke.

A. G. Clarke
Director
Medical Relations Division

CALEDONIA 5-1900

A physician asked us the question first—

A smoker himself, he asked: "What cigarette do most doctors smoke?"

We know that many physicians smoke, that many of them prefer Camels; but we couldn't answer the doctor's query.

We turned the question over to three nationally known independent survey groups. For months these three groups worked . . . separately . . . each one employing the latest scientific fact-finding methods.

This was no mere "feeling the pulse" poll. No mere study of "trends." This was a nationwide survey to discover the actual fact . . . and from the statements of physicians themselves.

> *To the best of our knowledge and belief, every physician in private practice in the United States was asked: "What cigarette do you smoke?"*

The findings, based on the statements of thousands and thousands of physicians, were checked and re-checked.

ACCORDING TO THIS RECENT NATIONWIDE SURVEY:

More doctors smoke Camels than any other cigarette

And by a very convincing margin!

Naturally, as the makers of Camels, we are gratified to learn of this preference. We know that no one is more deserving of a few moments to himself than the busy physician . . . of a few moments of relaxation with a cigarette if he likes. And we are glad to know that so many more physicians find in Camels the same added smoking pleasure that has made Camels such an outstanding favorite among *all* smokers.

CAMELS *Costlier Tobaccos*

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one, local, centralized, unified, voluntary health agency (exclusive of hospitals and clinics), with one board and one executive, with special committees and staffs to direct the work of special divisions: tuberculosis, visiting nursing, mental hygiene, social hygiene, etc."

Social Security Board Warns of Deficits

Says frozen tax rate would cut benefits after 1950

With an actual surplus of $7 billion, the Social Security Board fund earmarked for old-age benefits nevertheless has an actuarial deficit of $16.5 billion, SSB officials warned last month. And unless the present 2 per cent payroll deduction is revised upward or benefits are cut materially, the board asserted, it will not be able to meet all claims after 1950.

A subcommittee of the House Ways and Means Committee which has been surveying the fund was told that the actual surplus exists because relatively few persons who have paid into the fund have become eligible for old-age benefits. Current payments total about $250 million a year. But by 1955, says the board, payments will have increased to $2.5 billion a year while income from payroll taxation, now frozen by Congress at 1 per cent on the employer and 1 per cent on the employe, would make only $900 million available for old-age benefits.

According to Arthur J. Altmeyer, SSB chairman, the only thing that averted a current deficit was the return of half a million elderly persons to wartime employment. But, says Mr. Altmeyer, thousands of such persons are now retiring and applying for old-age benefits.

Both board officials and Congressmen have been suggesting solutions to the deficit problem. Mr. Altmeyer is still of the opinion that Congress erred in freezing the 1-and-1 per cent deduction this year, when under the law, it should have been raised to 2-and-2 per cent and 3-and-3 per cent later on. The SSB opposes permanent freezing of the taxation rate at its present level, with deficits to be made up by appropriations from general Government revenues. That plan is supported, however, by such people as Senator Arthur H. Vandenberg (R., Mich.).

WORLD RESEARCH. The New York Times feels that too little at-

tention has been given to a proposal made by Senator Brien McMahon (D., Conn.) to President Truman that the United Nations form a group of scientists, similar to those who engaged in atomic bomb research "to discover causes and cures for the deadly diseases of mankind." The Times emphasized the "need for employing human ingenuity, time, and money in conquering cancer and other diseases that take a heavy toll of life."

UNO IHO. The Senate Committee on Education and Labor has reported favorably on Senate Joint Resolution 89, which proposes the establishment of an international health organization under the United Nations Organization. Its functions: collection of statistics on disease; standardization and control of drugs and other therapeutic agents; assistance in the control of diseases at their sources.

PILOT. New York City's Public Health Research Institute has been so successful in its four years of operation, says The New York Times, that it might well serve as "a kind of pilot laboratory" for the National Research Foundation, now the subject of Congressional committee hearings. According to the Times:

"The fourth annual report of the institute testifies to the fine quality of work that has been done. Here is Dr. Jules Freund, who has developed an anti-malaria vaccine which is effective in ducks and monkeys and which, if it withstands the clinical tests now being conducted, may at last enable physicians to dispense with quinine and atabrine. And here are Drs. Alfred Cohn, Karl J. Thomson, and Boris A. Kornblith

A *New* APPROACH TO

MYOPATHIES

Basic Relief of

MYOSITIS
FIBROSITIS
FIBROMYOSITIS
AND KINDRED CONDITIONS

A NEW RATIONALE, quite different from the previous approach with rubefacients and counterirritants, places Myopone therapy in a field by itself.

Formulated to the new concept that myopathies are etiologically of local metabolic origin, topically applied Myopone apparently supplies a deficiency in affected muscular tissue. Utilization of the special solvent-extracted wheat germ oil contained in Myopone puts into action not only essential vitamin E but also phospholipids and other therapeutically active factors*.

FORMULA: Solvent-extracted wheat germ oil in a special absorption base.

Topical application of Myopone Ointment relieves soreness, eases tension, reduces swelling and stiffness.

Available in 1 oz. and 1 lb. jars at ethical pharmacies.

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*Ant, M., N. Y. State Jour. Med. Sept. 1, 1945

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18 West 44th St., New York 18, N. Y.

Please send sample of Myopone Ointment, reprint and literature to—

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MYOPONE
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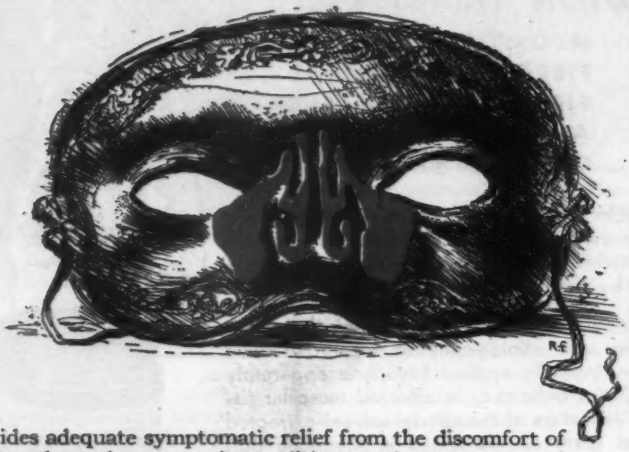
A DRUG PRODUCTS COMPANY *Specialty*

...remove the mask of nasal congestion!

PRIVINE HYDROCHLORIDE



provides adequate symptomatic relief from the discomfort of congested nasal passages in conditions such as coryza and allergic rhinitis. Privine has notable advantages which you and your patients will appreciate:

- **Dramatic promptness of action.**
- **Prolonged vasoconstriction.**
- **Non-interference with ciliary activity.**
- **Absence of irritation.**

Privine, accepted by the A. M. A. Council on Pharmacy and Chemistry, is offered in two concentrations: 0.1 per cent, recommended for adults only; 0.05 per cent for children, also found effective in many adult cases. Your pharmacy can supply Privine in bottles of 1 oz. and 16 ozs.

PRIVINE *Trade Mark Reg. U. S. Pat. Off. and in Canada*

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But, Mom, I'm not hungry!

Simple language for "anorexia"... most common presenting complaint in pediatrics.

A special preparation such as 'RYZAMIN-B' NO. 2 is needed to meet the distinctive requirements of children when a fortified, natural B complex is indicated. Tasty, honey-like, rich 'RYZAMIN-B' NO. 2 may be made into a delicious spread with jam or peanut butter, may be dissolved in milk, fruit juice, or other beverages, or given directly from its special measuring spoon. Children enjoy the delicious taste.

The potency and palatability of 'RYZAMIN-B' NO. 2, derived from natural sources as a concentrate of oryza sativa (American rice) polishings fortified with pure crystalline B vitamins, make it a preparation of choice for both young and old.

TUBES O. 2 OZ AND BOTTLES OF 8 OZ. Three grams daily provide: Vitamin B_1, (Thiamine Hydrochloride) 3 mgm. (1,000 U.S.P. Units), Vitamin B_2 (Riboflavin) 2 mgm., Nicotinamide 20 mgm. and other factors of the B complex. Gram measuring spoon with each packing.

'Ryzamin-B' registered trademark

'RYZAMIN-B' BRAND RICE POLISHINGS CONCENTRATE **No. 2**

with added thiamine hydrochloride, riboflavin, nicotinamide.

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with a method that makes a single massive dose of penicillin do the work of several smaller doses in venereal diseases.

"By testing a few drops of blood microchemically, another group of institute scientists has made it easy to establish the nutritional deficiencies of school children—a method so good that it has been adopted in voluntary hospitals for adult patients.

"The report is full of such examples," the Times declares, adding, "They demonstrate dramatically that when scientists are given a free hand they can do as effective work under the auspices of a municipality as they can under those of a university."

SEEING AID. Last month the Army Signal Corps had made a start toward an efficient "seeing aid" for the blind: A radar-like device had been completed and was in the process of being tested. Housed in a case like a lunchbox, the apparatus employs a light beam to pick out obstacles and translate them into code signals audible through an earphone worn by the blind person. Main drawback of the new device is its weight (9 lbs.). This and other wrinkles remain to be ironed out before the seeing aid approaches the modern hearing aid in convenience, lightness, and efficiency.

TAX STATUS. County medical societies are exempt from the payment of Federal income tax under two sections of the Internal Revenue Code only as long as they comply rigidly with the provisions of those sections, points out the Ka-

sas Medical Society, warning that a change in policy or method of operation may destroy the right to such exemption.

The two sections of the Internal Revenue Code under which county medical societies enjoy their tax exemption are cited by the Kansas association as follows:

Section 101(6), which exempts "corporations, and any community chest, fund or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual, and no substantial part of the activities of which is carrying on propaganda or otherwise attempting to influence legislation."

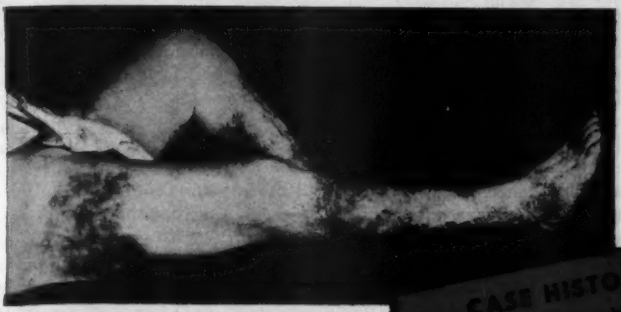
Section 101(7), which applies to "business leagues, chambers of commerce, real estate boards, or boards of trade or similar organizations not organized for profit and no part of the net earnings of which inures to the benefit of any private shareholder or individual."

According to the Kansas Medical Society, "No exemption will be allowed unless all the qualifications in one or the other of the sections are met. It is readily seen that a medical society taking any interest in the formulation of legislation will not be exempt under Section 101(6): Under Section 101(7) certain legislative activities are permitted, but in neither instance is compensation permitted for any member of the society."

A particular threat to tax exemption, it is pointed out, is the contract between a welfare board and a county medical society, whereby the latter agrees to furnish medical care to indigents through its members, among whom it divides the funds received from the municipal authorities. It is said to have been held that such contracts render the county society taxable, since net earnings inure to the benefit of private individuals and that if a society wishes to retain its status as a scientific or service organization, contracts of the type described must be abandoned.

On the other hand, the Kansas association comments, members may contract to provide indigent care without the society being a party to the transaction. For example, one physician might contract under his own name in behalf of the others.

Societies which have been declared subject to taxation by the Bureau of Internal Revenue are also



CASE HISTORY

White male, age 62. Severe bilateral varicities of lower extremities, with cellulitis and thrombophlebitis of right leg. Responded to 30,000 units Penicillin, administered intramuscularly every 3 hours, with recovery in 8 days.

PENICILLIN in CELLULITIS

Serious local infections such as cellulitis due to hemolytic streptococcic infections—with or without bacteremia—respond rapidly and dramatically to Penicillin.

Initial dosage of 15,000 to 20,000 units is advised. Constant intravenous injection of an isotonic sodium chloride solution follows, allowing administration of 5,000 to 10,000 units every hour, or 120,000 to 240,000 units in a twenty-four hour period. If this method is found inadvisable, 20,000 to 40,000 units may be injected intramuscularly every three or four hours.

Bristol Penicillin, because of its low toxicity, freedom from pyrogens, its sterility and its uniformity and potency, provides dependable chemotherapeutic action.

For additional current literature on the clinical uses of this potent antibiotic, refer to your issue of the BRISTOL PENICILLIN DIGEST.

Other products of Bristol Laboratories include Salicylate preparations and combinations such as Ephedrine Hydrochloride, Liver Injection, Estrogenic Substance in Oil, and Phenobarbital Sodium.

BRISTOL LABORATORIES INCORPORATED

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Formerly Claplin Laboratories Inc.

taxable under the Social Security Act, for it is held that doctors participating in a welfare board contract to which the society is a party are automatically employes of the society. For this additional reason, the Kansas society suggests, contracts should be made by an individual and not by a society.

A medical association is required to file its first tax exemption affidavit on Form 1023 or 1024, depending upon its method of organization. These forms require detailed information about the society's charter, constitution, activities, finances, etc. Using this information, the Bureau of Internal Revenue determines the society's tax status. If an organization is declared tax exempt, it must thereafter file an annual information return not later than the fifth month after the close of its fiscal year. Short Form 990 may then be employed, since the detailed information first required need not be reported again unless the activities of the society change.

JAMES MURRAY looked down his nose at S.191, the Hill-Burton hospital construction bill. It was a step forward, the Senator told his colleagues, but not a very big one. For one thing, he said, the program would give little to the neediest communities or to the poorest people.

It's commendable, he declared, to build adequate hospital facilities for a poor community, but who is going to support them? "Something could be accomplished toward meeting this problem if the Social Security Act were amended to permit Federal matching of funds paid

by states and localities for hospital care of needy persons, especially if the Federal matching were on a variable basis adjusted to the relative financial resources of the states." On the other hand, the Senator thought that even this would "aid only a fraction of the population involved, because the means test would still stand between the hospitals and those who are otherwise self-supporting yet cannot pay their way for hospital care."

The only practical way to tackle this problem, concluded the co-sponsor of the Wagner-Murray-Dingell bill, "is along the lines which Senator Wagner and I have worked out in S.1050, by broadening and strengthening the social security program."

RESEARCH. The National Research Foundation proposed by Dr. Vannevar Bush was being endorsed in principle a month ago at Senate committee meetings. But there was considerable difference of opinion as to how it should be headed: by one man or many. Vice Admiral Ross T. McIntire, Surgeon General of the Navy, was in favor of "straight-line administration" by a single director. Others, speaking through Dr. Homer W. Smith, of New York University, advocated control by a board.

Two bills are pending in Congress to implement the report of Dr. Bush, which proposes a program of grants and scholarships costing $122 million a year. One bill, sponsored by Senator Harley M. Kilgore (D., W. Va.), would place control of the National Research Foundation in the hands of a single administrator who would be advised by a board composed of scientists and laymen. The other measure, introduced by Senator Warren G. Magnuson (D., Wash.), would place the foundation under the direction of a board, whose members would elect the director and supervise his administration.

Opponents of the Kilgore proposal—including medical educators, industrialists, scientists, and research authorities—interceded with President Truman to oppose the bill. For one thing, they said, it might mean the creation of a "scientific Hitler" in this country. They also believed that the presence, ex officio, of Government officials on the foundation board, "with the right to petition for public funds for their own particular interests, is terrifying to men of science."

Receiving respectful consideration meanwhile was a plan that had been tested in New York City. When that metropolis was threatened by an infantile paralysis epidemic several years ago, it set up a research organization embracing two advisory committees: one scientific, one administrative. The scientific committee was composed of representatives of the various specialties concerned with poliomyelitis: virology, neurophysiology, epidemiology; pe-

In Estrogenic Therapy TOLERANCE

One of the important advantages of "Premarin" lies in the fact that it is exceptionally well tolerated. Although highly potent, "Premarin" rarely produces unpleasant side effects – a statement which finds ample corroboration in the extensive bibliography. In "Premarin" the physician will find a medium for estrogenic therapy which is noted for its therapeutic effectiveness. "Premarin" is derived exclusively from natural sources and its administration is usually followed by what is invariably described by the patient as a general feeling of well-being.

ESSENTIALLY SAFE • HIGHLY POTENT
ORALLY ACTIVE • NATURALLY OCCURRING • WATER SOLUBLE
WELL TOLERATED • IMPARTS A FEELING OF WELL-BEING

"Premarin" *TABLETS conjugated estrogens (equine)*
Reg. U. S. Pat. Off.

Available in 2 potencies.

Ayerst

No. 866 (the YELLOW tablet), in bottles of 20, 100 and 1.000 tablets.
No. 867 Half-Strength (the RED tablet), in bottles of 100 and 1,000 tablets.

AYERST, McKENNA & HARRISON LTD., 22 E. 40 St., New York 16, N. Y.

diatrics, orthopedic surgery, and physical medicine. The administrative committee consisted of persons familiar with the administrative aspects of epidemic control—*e.g.*, representatives of medical societies, visiting nurse associations, and crippled children's organizations. This committee formulated an administrative program based on the scientific principles developed by the scientific committee. The entire program was under the direction of the commissioner of health.

Dr. David D. Rutstein, deputy health commissioner of New York, told Senate committeemen that a similar set-up would be desirable for the National Research Committee. He proposed

1. A director to be appointed by the President with the approval of the Senate.

2. A scientific advisory council, to be appointed by the President, which would not only advise the director on scientific projects and appoint, with his consent, scientific advisory subcouncils on particular problems, but would also serve as a court of appeals (with the right of appeal to the President in the event of a major disagreement with the director).

3. An administrative council, to consist of representatives of Government, universities, science, industry, labor, and the public, to advise the director on his administrative functions and in the planning of broad programs based on the advice provided by the scientific council.

"Such an administrative plan," said Dr. Rutstein, "provides safeguards which will permit the fulfillment of a basic principle of good

Here is That Gauztex

You Have Been Hearing About

Gauztex is white surgical gauze treated so that it sticks to itself, but *only* to itself—never sticks to skin, hair or clothing.

Dressings are quickly, easily prepared and applied, and removed without pulling skin or hair and with minimum disturbance of wound. Leaves no gum or other stains. The special treatment given the gauze leaves it porous, permitting free entrance of air.

Oil Resistant Gauztex will not come off in oil, gasoline, naphtha or water. It is white, soft, pliable, dry, porous, cohesive and guaranteed to remain cohesive. Gauztex is widely used by the profession in private practice and in industrial practice where hundreds of thousands of rolls are used annually.

Chrysler, International Harvester, Studebaker, the various aircraft plants and thousands of factories in most every industry are all regular users. Manufactured only by General Bandages, Inc., 531 Plymouth Court, Chicago 5, Ill., and sold by all physicians' supply houses everywhere.

Free Samples

An adequate supply of samples is available to all in the profession for testing the practicality and applicability of Gauztex in any specific practice. We welcome your requests.

GAUZTEX

THE SELF ADHERING GAUZE

terra firma

The management of hemorrhoids rests on solid therapeutic grounds when it achieves relief without resort to dangerous local narcotization or anesthetization. 'ANUSOL'* Hemorrhoidal Suppositories contain neither anesthetic nor narcotic agents and so can never mask the symptoms of more serious rectal pathology. Quick, safe relief is attained by the removal of inflammatory pressure on the nerve endings. Burning and itching are soothingly abated while demulcent protection guards against the complications of bleeding and infection.

for additional pharmaceutical information consult your pharmacist—
for more extensive medical data write the Medical Division.

Schering & Glatz, Inc., *a subsidiary of* WIL[illegible]

*Trademark Reg. U. S. Pat. Off

'anusol'

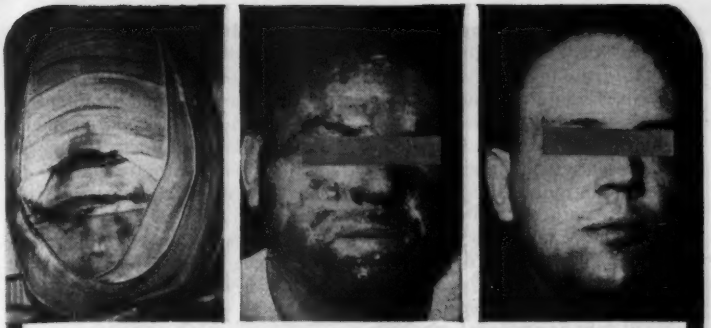
Hemorrhoidal Suppositories

Boxes of 6 and 12 suppositories

administration, that is, to concentrate authority and responsibility where it can be identified. This plan also provides for the necessary safeguards against bureaucratic domination of scientific endeavor by the director or his subordinates. The right of appeal will serve to prevent capricious administration on the part of the director. At the same time, his appointment by the President will protect the interests and welfare of the people and, in the light of atomic power, perhaps their very existence."

DOCTOR'S DAY. Commenting that Dr. George Elliot MacKinnon is a Scotchman who should be worth a quarter of a million dollars, but isn't because he periodically burns his unpaid account cards in an old-fashioned stove, the Milwaukee Journal recently gave much space to an account of "Dr. MacKinnon Day" in Prentice, Wis., a celebration which was also featured by Life magazine. Said the Journal:

"Dr. MacKinnon didn't know what the townspeople were cooking up behind his back, but it was plenty. Thursday morning, after being 'stork' twice during the night, he was at his office attending a dozen patients . . . From almost every home in Prentice poured Dr. MacKinnon's youngsters. The bus from Ogema disgorged dozens . . . Then a bus arrived from Catawba, another from Harmony, still another from Tripoli . . . Then the parade. Standing alone on a small platform, Dr. MacKinnon reviewed the procession . . . nice youngsters in white satin . . . the American Legion with the colors, floats, and such, a team of oxen, the old horse and buggy he had used, but, most important, the children the good doctor had helped



Case X—Massachusetts General Hospital Patient—Victim of Cocoanut Grove Fire.

NO. 1—2nd degree burns of face and ears and 3rd degree scalp burn covered by primary occlusive dressing on night of admission. Patient had a total burn surface of 12.5%.

NO. 2—As first head dressing was changed on seventh day, remnants of destroyed skin and dry serum are still present and uninfected.

NO. 3—Final view of the face on the 55th day showing absence of scarring, and normal contours. The scalp healed without grafting.

'VASELINE' PETROLEUM JELLY is the world's leading brand of PETROLATUM U.S.P.

PETROLATUM in the Surface Treatment of BURNS

IN describing treatment of surface wounds of burn casualties following Boston's Cocoanut Grove fire, this simple technique was reported as "eminently satisfactory":*

1. No debridement of burn surface.
2. No cleansing of the burn surface.
3. Bland ointment with protective dressing (". . . boric acid in petrolatum is safe").*
4. Chemotherapy administered internally.

This treatment, given extensive use following the disaster* has the advantage of simplicity. There is less manipulation of the patient, important in consideration of shock. There is quicker relief of pain, with less rolling as necessitated in debridement and cleansing. Earlier relief of pain, too, by prompt covering.

Since infection originates almost entirely from surface contamination following the burn injury, it is pointed out that the earlier the wound can be covered, the less the infection. Thus this simple, early covering method becomes a measure against infection.

In treatment of burn surfaces the physician will find 'Vaseline' Petroleum Jelly—plain or borated—is prompt and effective.

*Ann. of Surg. 117:885 (June) 1943.

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PETROLEUM JELLY

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CHESEBROUGH MANUFACTURING CO., CONS'D,
NEW YORK, N. Y.

to start life. There were fully 500 of them, tots that had to do double time to keep up, husky youths in uniform, all saluting him.

"Just as F. P. McCormick, president of the Chamber of Commerce, was presenting the doctor with a gift at the night reception there came an emergency call . . ."

Yes, Dr. MacKinnon had to go out and make another delivery.

WHO'S FIRST? Medical plans without physicians are unsalable, warns Lester H. Perry, executive secretary, Pennsylvania Medical Society. "When our representatives go out to sell prepaid medical service, the first question asked by an intelligent manager is 'What doctors are cooperating?' You can imagine the reaction if you say, 'Well, you get your employes to come along. After we have subscribers in this area the doctors will come along.' His answer: 'If the plan is any good, the doctors should come first.' And he's right. Our product is the intelligence and skill—the brains and the hands—of doctors. If we don't have that to sell, how can we expect anybody to buy?"

PIONEER in a new "specialty" is Dr. Amos Little, Marlboro, Mass. As an Army Air Force rescue-unit captain, Dr. Little made a total of forty-seven parachute leaps; he now plans to continue in rescue work as a civilian career. "There's a real need for it," he told the Associated Press. "Many people who are stricken in the mountains or in other spots die because medical care doesn't reach them soon enough. This is an age of improvements. Soon there will be doctors specializing in parachute rescue work. They'll be ready at a moment's notice to leap to the aid of the injured or the sick, thus reaching them hours—even days—before they could be rescued by conventional means."

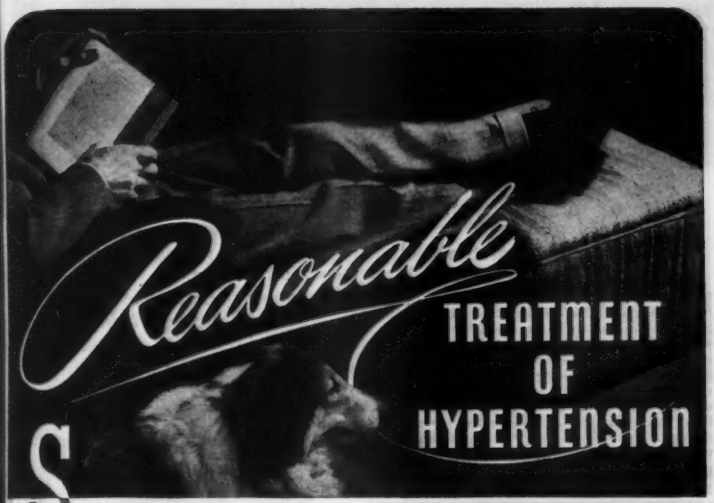
MEDICAL CORPS. A series of articles in Scripps-Howard newspapers dealing with the "freeze" of medical officers in the Army and Navy has brought letters from both the officers and their wives, says the New York World-Telegram, which quotes a number of them:

"If the doctors represented a big bloc of votes they would be coddled like the labor unions instead of being treated so unfairly . . ."

"Have the refugee doctors fulfilled the same strict license and specialist requirements which our own doctors have to meet? Their offices sprang up on every corner in New York. They coined money during the war. Why can't they be sent to take care of the armies of occupation . . . ?"

"My husband was certainly more essential to his community than he has been in the Army. He has not done one bit of constructive work since entering it . . ."

"In the Army for three years, I have not seen a patient since June



Successful management of high blood pressure calls for a regimen which is adjusted to individual requirements. Physical activity is generally curtailed and overwork is avoided. In certain circumstances special diets are prescribed and the use of stimulants is restricted.

These measures are often supplemented with the administration of Theominal. This combined vasodilator and sedative aids in reducing blood pressure to a more normal level. As a consequence hypertensive symptoms are relieved and the risk of complications is reduced.

DOSAGE: The customary dose of Theominal is 1 tablet two or three times daily; when improvement sets in the dose may be reduced. Each tablet contains theobromine 5 grains and Luminal* ½ grain.

*Luminal (trademark), Winthrop Chemical Company, Inc., brand of phenobarbital.

WINTHROP **Theominal**

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Supplied in bottles of 25, 100 and 500 tablets.

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Pharmaceuticals of merit
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29, 1945, while waiting in England for a discharge or reassignment."

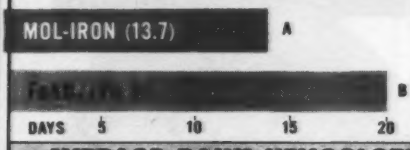
UNLICENSED TRAINER. Jules H. Freedman, trainer of the Jersey Giants, professional baseball team, has been acquitted of charges brought by the New Jersey State Board of Medical Examiners that he practiced medicine without a license in giving physiotherapy treatments in his office.

A number of persons testified that Freedman had given them baking and massage therapy. However, in discharging the defendant, Judge William E. Sewell, First District Court, Jersey City, said it was difficult to draw a line between treatments given by Freedman and those given in gymnasiums sponsored by organizations like the YMCA and Knights of Columbus. "I am inclined to feel," said Judge Sewell, "that Freedman was well-equipped to give such treatments in view of his wide experience in the field and of the fact that he is employed by a professional baseball club and in charge of all its players."

INTACT. Back in New York last month was the Ninth Evacuation Hospital Unit (the "Roosevelt Hospital Group") without a single major casualty among its staff of forty-four doctors, fifty-two nurses, and a chaplain. Its chief, Lieut. Col. Gurney Taylor, said that no one on the staff had been killed because "we were never strafed or bombed. The Red Cross insigne was always respected." The colonel reported that the unit had cared for 54,000 patients and performed 16,000 operations. During the German breakthrough in the Kasserine Pass in North Africa, the hospital group re-

A NEW AND DEFINITE ADVANCE

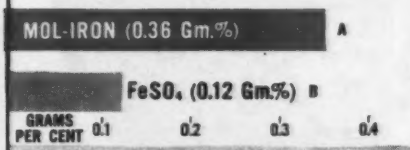
RAPIDITY OF CLINICAL RESPONSE (Days)



(A) Completely effective therapeutic response return to normal blood values obtained in an average of 13.7 days Mol-Iron therapy.

(B) Ferrous sulfate therapy failed to produce normal hemoglobin values after an average of 20.3 days.

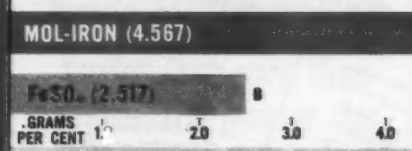
AVERAGE DAILY HEMOGLOBIN INCREASE (Gm. Per Cent)



(A) The group treated with Mol-Iron averaged a daily hemoglobin increase of 2 per cent (0.36 Gm. per cent).

(B) The group treated with ferrous sulfate showed an average daily gain of hemoglobin of 0.83 per cent (0.12 Gm. per cent), a response about one third as effective.

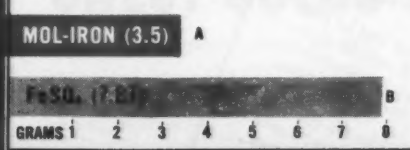
TOTAL HEMOGLOBIN INCREASE (Gm. Per Cent)



(A) The total hemoglobin increase (average of 13.7 days) averaged 3 cent (4.56 Gm. per cent) in the Mol treated group.

(B) A mean gain of only 17 per cent Gm. per cent) hemoglobin resulted in an age period of 20.3 days during which ferrous sulfate treated group was ob

THERAPEUTIC INTAKE OF BIVALENT IRON (Gm.)



(A) The Mol-Iron treated group received an average total 3.528 Gms. of bivalent iron to produce the sought for result (return to normal blood values).

(B) While an average ingestion of 7 Gms. of bivalent iron failed to achieve optimal response in the ferrous sulfate treated group.

The charts summarize the results of a controlled study of comparative therapeutic response in post-hemorrhagic and nutritional hypochromic anemias.

The series includes 19 cases treated with Mol-Iron and 21 with desiccated ferrous sulfate; the results are typical of those observed in treatment of iron-deficiency anemias with Blaud's Mol-Iron.

...in Treating Iron-Deficiency Anemias

A specially processed, co-precipitated complex of molybdenum oxide (3 mg.) and ferrous sulfate (195 mg.).

White's MOL-IRON TABLETS

Available clinical evidence indicates that, in hypochromic anemia, the therapeutic response to this highly effective synergistic combination—as compared with equivalent dosage of ferrous sulfate alone—has unusual advantages:

1. NORMAL HEMOGLOBIN VALUES ARE RESTORED MORE RAPIDLY, INCREASES IN THE RATE OF HEMOGLOBIN FORMATION BEING AS GREAT AS 100% OR MORE IN PATIENTS STUDIED.
2. IRON UTILIZATION IS SIMILARLY MORE COMPLETE.
3. GASTRO-INTESTINAL TOLERANCE IS NOTABLY SATISFACTORY—even among patients who have previously shown marked gastro-intestinal reactions following oral administration of other iron preparations.

INDICATED IN: Hypochromic (iron-deficiency) anemias caused by inadequate dietary intake or impaired intestinal absorption of iron; excessive utilization of iron, as in pregnancy and lactation; chronic hemorrhage.

DOSAGE: One or two tablets three times daily after meals.

Available in bottles of 100 and 1000 tablets. Ethically promoted—not advertised to the laity.

PHARMACEUTICAL White MANUFACTURERS

treated 50 miles in one night—taking 400 patients with it to safety.

Relocating Veterans Must Qualify in Most States

Medical boards generally hold to prewar licensure rules

A survey of states and territories on the licensure of medical officers who desire to relocate (after demobilization) has been completed by the Federation of State Medical Boards and presented to the AMA. Here is a summary of the report, prepared by Dr. Walter L. Bierring:

Medical officers who are graduates of approved medical schools must be able to satisfy the peacetime licensure requirements of the state in which they wish to relocate. Exceptions: New York, North Dakota, and Pennsylvania, which are giving special consideration to the problem.

Graduates of unapproved schools will find it difficult to obtain a license in any state except Illinois and Massachusetts. Arizona, Georgia, and New York appear willing to give special consideration to such applicants. In this connection, two additional requirements were suggested by the federation: (1) a complete, certified statement of medical military service; and (2) one year of attendance in an approved medical school and certification of such attendance by its dean.

Medical officers who have never had a license will evidently be required to take the regular licensure examination in the states they choose for location. (Diplomates of the National Board of Medical Ex-

aminers will be exempt from such examinations wherever the certificate of the board is accepted). Vermont has expressed a liberal attitude toward such applicants.

SUPER BABIES. Washington, a month ago, was enjoying one of its one-day sensations: a proposal that the nation construct a network of "virgin hospitals," wherein "virtuous, high-minded women who are unable to marry" would be artificially impregnated with semen from "selected" donors in the armed forces. According to the United Press, the proposal was receiving rousing support among service men, but not among relatives of the 70-year-old Washington woman who originally advanced the idea. Embarrassed, they persuaded her to withdraw from "further publicity in the matter."

Some service men and veterans called the elderly sponsor "one of Hitler's children" and a "crackbrain," but many were reported to have volunteered as donors. Two veterans of Iwo Jima wrote from the Naval Hospital at Bethesda, Md., that fifty-one men in their ward were "eager to father one of these children."

POSTPONED. Dr. Edward Broderick, discharged from the Army, had good reason to hurry toward Needham, Mass., relates columnist Joseph F. Dinneen in the Boston Globe: His wedding anniversary was only four days off. "The doctor covered 1,900 miles in less than four days, driving six hours and resting twelve as a couple of 'thumbers'—an ensign and a private—did six hour turns at the wheel. You learn to organize projects like that when

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(equal parts of sulfa*thiazole* and sulfa*diazine*)

in one tablet

TO REDUCE RENAL TOXICITY INCIDENT TO SULFONAMIDE THERAPY

Recent experimental and clinical studies[1,2] prove that administration of sulfathiazole and sulfadiazine in combination in equal parts reduces renal complications such as crystalluria, hematuria and urinary tract blockage, and is much safer than either drug used alone in whole dosage. Simultaneously, antibacterial activity and therapeutic efficacy are maintained.

COMBISUL-TD presents 0.25 gram sulfathiazole and 0.25 gram sulfadiazine—a total of 0.5 gram per tablet. No signs of renal toxicity have been encountered by use of this mixture and even crystalluria isinfrequent. The indications for, and dosage of, COMBISUL-TD are the same as for either drug administered alone. Meningitis is an exception, for which COMBISUL-DM, a combination of 0.25 gram sulfadiazine and 0.25 gram sulfamerazine is available.

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1. Lehr, D.: Proc. Soc. Exper. Biol. & Med. *58*:11, 1945.
2. Lehr, D.: In press.

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IN CANADA, SCHERING CORPORATION LIMITED, MONTREAL

you're in the Army. As he lost each thumber, he picked up a replacement, making certain that the new man could drive.

"Just before noon on the anniversary, he rolled into his old familiar driveway, hopped out of his car, rushed into the kitchen, cried 'Happy anniversary' to his surprised wife, and kissed her. Before he could take off his uniform coat, the doorbell rang. A garbage collector had been bitten on the ankle by a dog. Dr. Broderick knew that he was home."

ADOPTION LAW. Two separate drives were under way a month ago in Washington to amend the District of Columbia's "baby brokerage" act, which recently resulted in the prosecution of a physician on the ground that he had acted as an unlicensed broker in introducing the principals in an adoption case.

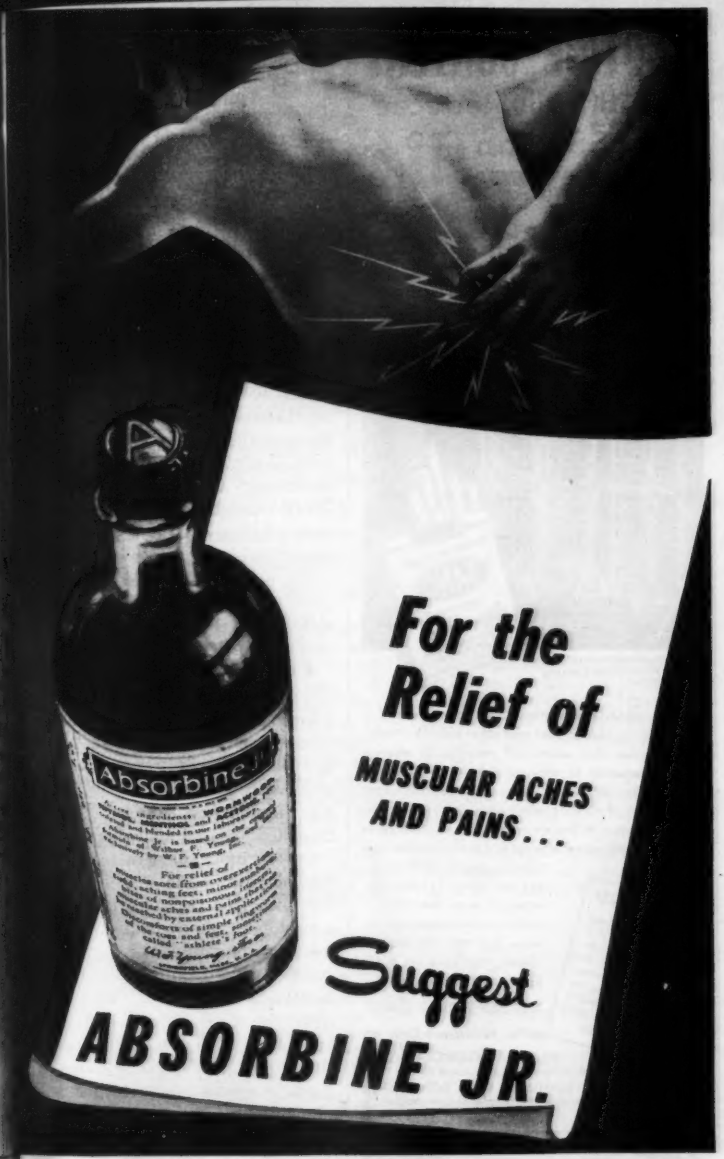
A committee of lawyers has demanded that the law be changed so that physicians, lawyers, and clergymen may participate in the placing of orphans without being licensed, as long as they are not paid for their services. On the other hand, the Children's Protective Association would make the law more stringent. It would require even a mother to consult with a social agency before relinquishing her child an adoption.

While both bodies are agre that the law, in effect less than year, has ended the "black mar in babies" in the nation's capi driving out of business those w had been finding children for ea persons willing to pay exorbit fees, the lawyers contend that "good citizen" should be penali because he knows of a baby in n of a home and can arrange to br it into a good one. The Childr Protective Association retorts even the best-intentioned citi cannot possibly be a good judge a child's needs. Even for welf workers, it points out, there is c siderable difficulty in "matchi a child with foster parents, sinc takes a good deal of insight and perience to determine whether couple have the necessary stabil understanding of children, and w ingness to sacrifice.

INDUSTRIAL STUDY. When ODT ban on rail travel forced pension of the Indiana State M cal Association's intensive two- course in industrial medicine, merly conducted each year in dianapolis, a decentralized prog

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrasing incident that has occurred in your practice. Contributors may remain anonymous upon request. Address Medical Economics, Rutherford, N.J.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For the Relief of
MUSCULAR ACHES AND PAINS...
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was successfully undertaken by f
of the state's county medical soc
ties. One of them (Grant Count
developed what has been describ
as the first "in-plant meeting" in t
state. Working with the mana
ment of the Gas City plant of t
Owens-Illinois Glass Co., the soc
ty arranged for an inspection of t
factory by interested physicia
These men, says Dr. Louis W. Sp
yar, of the Indiana State Board
Health, "actually saw all operati
and control measures used. A
the tour, all phases of indust
health were covered at a round
ble discussion. The physicians as
the management questions, and
management asked the physici
questions. One doctor remark
'Until tonight I had no clear
idea what my patients were talk
about when they told me that t
had a certain job to do, or that t
were exposed to this or that ma
rial. Now I think I know.'"

CONTRIBUTIONS. Doctors
others who may be asked to c
tribute to new charity drives or
let sponsors list their names as m
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given this warning by the Contr
tors Information Bureau of the W
fare Council of New York C
"Never give money or agree to
use of your name in response t
telephone or personal appeal fr
a solicitor unknown to you. Alw
ask for the appeal in writing."
New York, the bureau gives co
dential information to all inqui
as to the status of any drive or
organization about which they'r
doubt. In addition, it helps N
Yorkers check their entire list
charities by indicating on a s
mitted list its opinion of their wo

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Mark well the word—"SODASCORBATE". Underscore it in your mental notebook. Photograph it in your mind. For SODASCORBATE offers distinct advantages to your patients who require vitamin C therapy, but who are unable to tolerate ordinary ascorbic acid.

The administration of this improved vitamin C is simplicity itself. The *first* and *only* sodium ascorbate in *dry*, neutral form, SODASCORBATE Tablets permit full and frequent doses of vitamin C without the gastric irritation, acid-shift or other undesired after-effects that so often result from large doses of straight ascorbic acid.

SODASCORBATE Tablets are indicated in clinical and subclinical scurvy, and in all conditions where vitamin C has been found of value. Recent studies suggest its use in infectious diseases and toxic conditions; in pregnancy and lactation; in allergies, especially hay fever; in some cases of gingivitis and pyorrhea; for lack of energy and endurance associated with vitamin C deficiency; and as a chlorine-free substitute for salt in heat exhaustion.

The average dose for adults and children over 12 years is one tablet three times daily, or as indicated by the condition. For children under 12, one-half tablet. This may be dissolved in milk for babies and young children.

Supplied in bottles of 40 and 100 tablets, as well as in "hospital-size" bottle containing 500 tablets. For professional samples and covering literature, sign and mail the coupon.

"NEW HORIZONS IN VITAMIN C THERAPY"

This 32-page monograph contains much interesting and valuable information on vitamin C therapy. Brief, concise, authoritative. Most comprehensive bibliography. Write for your copy.

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Pictures in This Issue

Pages 54, 55, 56, 57: National Physicians Committee. Page 66: Acme. Page 94: New York Herald Tribune.

"Oh Doctor

I have such an awful TOOTHACHE and I can't reach the dentist"

Thousands of physicians give the same advice...

"Use a POLORIS poultice"

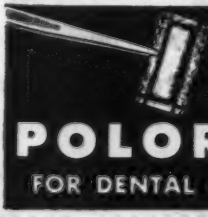
Your patient will be grateful if you prescribe Poloris Dental Poultice for emergency dental pain—because Poloris is singularly effective in giving prompt, safe relief—usually without the need for systemic opiates or sedatives.

You can suggest Poloris with the full assurance that it will not interfere with subsequent dental treatment.

Poloris—a strictly ethical product for over 30 years—is indicated for pain relief in the presence of dental abscess, after extraction, erupting third molar, irritation after filling, and other painful conditions of the teeth and gums not due to cavity.

Poloris is a scientifically tested and proven dental aid... acts on the medically accepted principle of counter-irritation. Its active ingredients include capsicum, hops, benzocaine, sassafras root, and hydroxyquinoline sulfate, in poultice form.

Obtainable at all drug stores.



POLORIS

FOR DENTAL PAIN

POLORIS CO., INC. 94A
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QUIETING

THE TROUBLED WATERS

. . . THROUGH ADEQUATE THERAPY OF THE MENOPAUSAL SYNDR

When menopausal disquietude threatens emotional stability, complete control of symptomatology—including alleviation of nervous disturbances and restoration of sense of well-being—becomes the primary therapeutic objective. ▪ In combining ample hormonal compensation with safe sedation, Hexital offers the physician a distinct advantageous estrogenic preparation. Hexital contains 3 mg. hexestrol (significantly less toxic than stilbestrol) and 20 mg. phenobarbital per tablet. ▪ Clinical evidence suggests that the combined use of hexestrol and phenobarbital (Hexital) reduces to a minimum untoward side effects, so often characteristic of synthetic estrin medication.

SUPPLIED: 100 and 1000 to the bottle, in scored tablets. Inexpensively priced.

ORTHO PHARMACEUTICAL CORPORATION, LINDEN, NEW JERSEY

hexital **(HEXESTROL-PHENOBARBITAL)**

A STEP FORWARD IN MENOPAUSAL THERAPY

"Ever diagnose a cake of soap, doctor?"

IVORY DOES ..WITH 216 TESTS FOR QUALITY, PURITY, MILDNESS

66 years of reputation stands behind every cake of Ivory Soap we make. That's why raw ingredients and fats are selected with special care.

That's why 216 tests guard each batch of Ivory. Then thousands of skin patch tests double-checks Ivory's safety in use.

Result? A soap free from coloring, strong perfume or impurities that might irritate baby skin. Such care makes Ivory the standard of purity and mildness to millions. Advise it with confidence.

99 44/100% pure

IT FLOATS